aetna™

Aetna Better Health®

Fax completed prior authorization request form to 877-309-8077 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/pennsylvania/providers/pharmacy

Central Nervous System Stimulants
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
Preferred Agents:	☐ amphetamine/dextroamphetamine	☐ dexmethylphenidate	☐ dextroamphetamine
	☐ methylphenidate IR	☐ methylphenidate ER	☐ methylphenidate LA
	☐ methylphenidate CD	☐ methylphenidate CR	
Non-Preferred Agents:	☐ Aptensio XR	☐ Daytrana	☐ Evekeo
	☐ Methamphetamine	☐ Quillivant XR	☐ Vyvanse
	☐ Contempla XR-ODT	☐ Other, please specify:	

Are there any contraindications to formulary medications? (If yes, specify):	☐ Yes	☐ No	☐ New request

Continuation of therapy for ADHD/ADD AND Narcolepsy:	☐ Attestation of response to therapy	☐ Continuation of therapy for Binge Eating Disorder:	☐ Continues to receive evidence based behavioral therapy
	☐ Attestation of member adherence to therapy		☐ Decrease in number of binge days per week.

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Refills:	Duration of Therapy/Use:

What medication(s) has the member tried and failed for this diagnosis?
Please specify:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature:_____

Medication request is NOT for FDA-approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:

Clinical Information		
General Authorization Criteria - ALL Agents and Indications		
Will member be taking ONLY ONE TYPE of stimulant medication as therapy (methylphenidate OR amphetamine-based drug)?	☐ Yes	☐ No
Is Short-Acting stimulant combined with Long-Acting stimulant of SAME drug type AND there is documentation that LA version is not lasting for sufficient daily duration?	☐ Yes	☐ No
☐ **Adults Over 18 Years of Age**		

☐ ADHD/ADD	☐ Idiopathic Hypersomnia	☐ Fatigue Related to Cancer or MS	☐ Narcolepsy

Is ADHD/ADD diagnosis documented in medical record AND based on comprehensive evaluation by appropriate specialist AND includes an evidence-based rating scale (for example but not limited to Adult Self Report Scale V1.1 (ASRS V1.1)).						☐ Yes	☐ No
Do symptoms meet Diagnostic and Statistical Manual of Mental Disorders (DSM5) criteria?	☐ Yes	☐ No	Are other conditions (depression, anxiety, conduct disorder or tics) ruled out OR are being appropriately treated?			☐ Yes	☐ No
If member has history of substance abuse disorder, was UDS included in the treatment plan?				☐ Yes	☐ No	☐ N/A	

☐ **Children 6 - 18 Years of Age**	
☐ ADHD/ADD	☐ Narcolepsy

Is ADHD/ADD diagnosis documented in medical record AND based on comprehensive evaluation by appropriate specialist OR primary care provider. Evaluation must include evidence-based rating scale (for example but not limited to Swanson, Nolan, Pelham-IV Questionnaire (SNAP-IV).						☐ Yes	☐ No
Do symptoms meet Diagnostic and Statistical Manual of Mental Disorders (DSM5) criteria.	☐ Yes	☐ No	Are other conditions (depression, anxiety, conduct disorder OR tics) ruled out OR are being appropriately treated?			☐ Yes	☐ No
If member has history of substance abuse disorder, was UDS included in the treatment plan?				☐ Yes	☐ No	☐ N/A	
Was evidence-based behavioral therapy (child, teacher, and/or caregiver) considered as part of treatment plan? (therapy can be ongoing, previously completed OR noted as not appropriate OR necessary in this case)						☐ Yes	☐ No

☐ **Children 5 year of Age and Under**		
Did symptoms of ADHD/ADD continue despite evidence-based parent AND/OR teacher-administered behavior therapy?	☐ Yes	☐ No

☐ **Non-Preferred Agents**					
Does member meet criteria noted above based on member age?	☐ Yes	☐ No	Was there adverse reaction OR contraindication to ALL PREFERRED agents that does not ALSO exist for requested NON-PREFERRED agent?	☐ Yes	☐ No
Did member fail to respond to at least 2 formulary stimulants (one from each of the stimulant subclasses) (for example, amphetamine-dextroamphetamine AND methylphenidate-dexmethylphenidate)?				☐ Yes	☐ No

☐ **Vyvanse for Binge Eating Disorder**					
Was DSM5 criteria met for diagnosis?	☐ Yes	☐ No	Was there inadequate response OR intolerance to at least 2 formulary medications used for Binge Eating Disorder (SSRIs, topiramate OR zonisamide)?	☐ Yes	☐ No
Is Body Mass Index >25 kg/m2?	☐ Yes	☐ No	Is member receiving nutritional counseling or psychotherapy?	☐ Yes	☐ No
Has member taken monoamine oxidase inhibitors in past 14 days?	☐ Yes	☐ No	Is there recent history of substance abuse?	☐ Yes	☐ No
Is member concurrently taking other stimulants?	☐ Yes	☐ No	Is there history of cardiac disease (arrhythmia, cardiac structural abnormalities, CAD)?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call to check the status of a request.
Pennsylvania CHIP:1-800-822-2447.