# TEXAS MEDICAID
# Clinical Edit Prior Authorization
# Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD) IR Formulations

| STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING | |
|---|---|
| Date: | Prescriber First & Last Name: |
| Patient First & Last Name: | Prescriber NPI: |
| Patient Address: | Prescriber Address: |
| Patient ID: | Prescriber Phone: |
| Patient Date of Birth: | Prescriber Fax: |

| STEP 2: MEDICATION INFORMATION | |
|---|---|
| Medication Requested (Name): | Quantity Requested: |
| Dose Requested: | Dosing Instructions: |

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

**OR** ☐ Preferred Drug **(Go to Step 4)**

**OR** ☐ No Status, Drug is not in a Market Basket **(Go to Step 4)**

**OR** ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

## STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

**STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA**

1. Is the client less than (<) 3 years of age?

   ☐ Yes (Deny) ☐ No (Go to #2)

2. Is the request for greater than (>) the Texas Department of Family and Protective Services (DFPS) maximum recommended daily dose?

   ☐ Yes (Deny) ☐ No (Go to #3)

3. Does the client have a paid claim for another IR stimulant in the past 14 days?

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Is the client less than (<) 6 years of age?

   ☐ Yes (Go to #5) ☐ No (Go to #6)

5. Is the request for ONE (1) of the following?
   - amphetamine/dextroamphetamine salts (ADDERALL)
   - amphetamine sulfate (EVEKEO ODT/tablets)
   - dexmethylphenidate (FOCALIN)
   - dextroamphetamine (DEXEDRINE, PROCENTRA, ZENZEDI)
   - methylphenidate (METHYLIN, RITALIN)

   ☐ Yes (Approve – 365 days) ☐ No (Deny)

6. Is the client greater than or equal to (≥) 19 years of age?

   ☐ Yes (Go to #7) ☐ No (Approve – 365 days)

7. Does the client have a diagnosis of ADD/ADHD in the last 730 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #8)

8. Does the client have a diagnosis of narcolepsy in the past 730 days?

   ☐ Yes (Go to #9) ☐ No (Deny)

9. Is the request for dexmethylphenidate (FOCALIN), EVEKEO ODT or methamphetamine (DESOXYN)?

   ☐ Yes (Deny) ☐ No (Approve – 365 days)

**STEP 5: SIGN AND FAX TO:** NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

**Prescriber Signature:** _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.

| IR Formulations DFPS Supporting Table | | | | |
|---|---|---|---|---|
| **Active Ingredient** | **Drug (brand)** | **Initial Dosage** | **Literature Based Maximum Dosage** | **FDA Approved Maximum Dosage for Children and Adolescents** |
| AMPHETAMINE/ DEXTROAMPHETAMINE SALTS | ADDERALL | Age 3-5 years: 2.5mg/day<br>Age ≥ 6 years: 5-10mg/day | Age 3-5 years: 30mg/day<br>Age ≥ 6 years (≤ 50kg): 40mg/day<br>Age ≥ 6 years (> 50kg): 60mg/day | Approved for children 3 years and older: 40mg/day |
| AMPHETAMINE SULFATE | EVEKEO<br>EVEKEO ODT | Age 3-5 years: 2.5-5mg/day<br>Age ≥ 6 years: 5-10mg/day | Age ≥ 3 years: 40mg/day | Approved for children 3 years and older: 40mg/day |
| DEXMETHYLPHENIDATE | FOCALIN | Age ≥ 6 years: 2.5mg twice daily | Age ≥ 6 years: 50mg/day | Approved for children 6 years and older: 20mg/day |
| DEXTROAMPHETAMINE | DEXEDRINE<br>PROCENTRA<br>ZENZEDI | Age 3-5 years: 2.5mg/day<br>Age ≥ 6 years: 5-10mg/day | Age 3-5 years: 30mg/day<br>Age ≥ 6 years (≤ 50kg): 40mg/day<br>Age ≥ 6 years (> 50kg): 60mg/day | Approved for children 3 years and older: 40mg/day |
| METHAMPHETAMINE | DESOXYN | 5mg daily | N/A | Approved for children 6 years and older: 25mg/day |
| METHYLPHENIDATE | METHYLIN<br>RITALIN | Age 3-5 years: 2.5mg twice daily<br>Age ≥ 6 years: 5mg twice daily | Age 3-5 years: 22.5mg/day<br>Age ≥ 6 years (≤ 50kg): 60mg/day<br>Age ≥ 6 years (> 50kg): 100mg/day | Approved for children 6 years and older: 60mg/day |