Aetna Better Health®

Fax completed prior authorization request form to 855-296-0323 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/newjersey/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:	☐ amphetamine/dextroamphetamine	☐ dexmethylphenidate	☐ dextroamphetamine
	☐ methylphenidate IR	☐ methylphenidate ER	☐ methylphenidate LA
	☐ methylphenidate CD	☐ methylphenidate CR	
Non-Preferred:	☐ Aptensio XR	☐ Daytrana	☐ Evekeo
	☐ Methamphetamine	☐ Quillivant XR	☐ Vyvanse
	☐ Other, please specify:		

Are there any contraindications to formulary medications?	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
If yes, please specify:				

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: _____

Clinical Information		
General Authorization Criteria for ALL Agents and Indications:		
Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No		
What is the diagnosis? IDC-10 Code: _____ Diagnosis _____		
Prescribed stimulant is a preferred formulary agent or member meets criteria for non-preferred stimulant as described below	☐ Yes	☐ No
Member will be taking only one type of stimulant medication as therapy (methylphenidate or amphetamine-based drug)	☐ Yes	☐ No
Short-Acting stimulant is to be combined with Long-Acting stimulant of the same drug type, and there is documentation that Long-Acting version is not lasting for the sufficient daily duration	☐ Yes	☐ No

Additional Guidelines for Adults over age 18 years		
Diagnosis:	☐ ADHD/ADD	☐ Fatigue related to cancer or multiple sclerosis
	☐ Idiopathic Hypersomnia	☐ Narcolepsy

Initiation of stimulant for ADHD/ADD must meet all the following:			
ADHD/ADD diagnosis is documented in medical record and is based on comprehensive evaluation by appropriate specialist and includes an evidence-based rating scale (for example but not limited to Swanson, Nolan, Pelham-IV Questionnaire (SNAP-IV), Adult Self Report Scale V1.1 (ASRS V1.1)). Symptoms meet the Diagnostic and Statistical Manual of Mental Disorders (DSM5) criteria		☐ Yes	☐ No
Other conditions, such as depression, anxiety, conduct disorder or tics, have been ruled out or are being appropriately treated		☐ Yes	☐ No
If there is a history of substance abuse disorder, a urine drug screen is included in the treatment plan (does not require submission of results)	☐ Yes	☐ No	☐ N/A
Additional Guidelines for Children Ages 6 through 11 years			
Diagnosis:	☐ ADHD/ADD	☐ Narcolepsy	
Initiation of stimulant for ADHD/ADD must meet all the following:			
ADHD/ADD documented in medical record and based on comprehensive evaluation by appropriate specialist or primary care provider. The evaluation must include evidence-based rating scale (for example but not limited to Swanson, Nolan, Pelham-IV Questionnaire (SNAP-IV)		☐ Yes	☐ No
Other conditions (such as depression, anxiety, conduct disorder or tics) have been ruled out or are being appropriately treated		☐ Yes	☐ No
For members with history of substance abuse disorder, a urine drug screen is included in the treatment plan (does not require submission of results).	☐ Yes	☐ No	☐ N/A
Evidence-based behavioral therapy (child, teacher, and/or caregiver) has been considered as part of treatment plan. Therapy can be ongoing, previously completed or noted as not appropriate or necessary in this case.		☐ Yes	☐ No
Additional Guidelines for Adolescents Ages 12 through 17 years			
Diagnosis:	☐ ADHD/ADD	☐ Narcolepsy	
Initiation of stimulant for ADHD/ADD must meet all the following:			
ADHD/ADD is documented in medical records and based on comprehensive evaluation by appropriate specialist or primary care provider.		☐ Yes	☐ No
The comprehensive evaluation includes an evidence-based rating scale (for example but not limited to Swanson, Nolan, Pelham-IV Questionnaire (SNAP-IV)		☐ Yes	☐ No
Other conditions (depression, anxiety, conduct disorder or tics) have been ruled out or are being appropriately treated		☐ Yes	☐ No
For members with history of substance abuse disorder, a urine drug screen is included in the treatment plan (does not require submission of results)	☐ Yes	☐ No	☐ N/A
Additional Guidelines for Children Age 5 and Under **(These requests will be reviewed on a case-by-case basis by the Plan Medical Director)**			
Symptoms of ADHD/ADD continue despite evidence-based parent and/or teacher-administered behavior therapy		☐ Yes	☐ No
Additional Guidelines for Non-Preferred Agents			
Member meets criteria noted above based on age?	☐ Yes	☐ No	
Member has adverse reaction or contraindication to all preferred agents that does not also exist for the requested non-preferred drug	☐ Yes	☐ No	☐ N/A
Member failed to respond to at least 2 formulary stimulants (one formulary stimulant from each of the stimulant subclasses) (for example, amphetamine/dextroamphetamine and methylphenidate/ dexmethylphenidate).		☐ Yes	☐ No
Requests for non-preferred, EXTENDED RELEASE product, requires failure of EXTENDED RELEASE formulation of preferred agents	☐ Yes	☐ No	☐ N/A
Requests for non-preferred IMMEDIATE RELEASE product, requires failure of IMMEDIATE RELEASE formulation of preferred agents	☐ Yes	☐ No	☐ N/A
Authorization Guidelines for Vyvanse for Binge Eating Disorder			
The Diagnostic and Statistical Manual of Mental Disorders (DSM5) criteria has been met for diagnosis	☐ Yes	☐ No	
Body Mass Index (BMI) is greater than 25 kg/m2?	☐ Yes	☐ No	
Is patient receiving nutritional counseling or psychotherapy?	☐ Yes	☐ No	
There was inadequate response or intolerance to at least 2 formulary medications used for Binge Eating Disorder (for example, selective serotonin reuptake inhibitors (SSRIs), topiramate, or zonisamide)	☐ Yes	☐ No	
Has patient taken monoamine oxidase inhibitors in the past 14 days?	☐ Yes	☐ No	
Is there a recent history of substance abuse?	☐ Yes	☐ No	
Is patient concurrently taking other stimulants?	☐ Yes	☐ No	
Is there history of cardiac disease (arrhythmia, cardiac structural abnormalities, coronary artery disease)	☐ 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 855-232-3596 to check the status of a request