STIMULANTS AND RELATED AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/8/2024)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:		
Specialty:	NPI:	State license #:
Street address:		
Suite #:	City/state/zip:	
Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	
Dosage form (tablet, ODT, suspension, etc.):	Quantity:	# months requested:
Diagnosis *(submit documentation)*:	Diagnosis code (required):	

INITIAL REQUESTS

Has the beneficiary been taking the requested medication within the past 90 days?	☐ Yes ☐ No	*Submit documentation*
For a non-preferred drug: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred drugs in this class that are approved or medically accepted for treatment of the beneficiary's condition? Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred drugs in this class.	☐ Yes ☐ No	*List preferred medications tried:*

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ **For an analeptic Stimulants and Related Agents (e.g., Provigil, Nuvigil, Sunosi, Wakix)**
- ☐ Is not receiving concurrent treatment with sedative/hypnotic medications
- ☐ Is receiving concurrent treatment with sedative/hypnotic medications — reason:_____

☐ **For the treatment of narcolepsy:**
- ☐ Has a diagnosis of narcolepsy that is consistent with current International Classification of Sleep Disorders criteria (e.g., MSLT, overnight PSG, hypocretin-1 concentration, clinical assessment, etc.)

☐ **For the treatment of shift work sleep disorder:**
- ☐ Has a diagnosis of shift work sleep disorder that is consistent with current International Classification of Sleep Disorders criteria (e.g., shift work schedule, sleep log and actigraphy monitoring, other causes ruled out, clinical assessment, etc.)

☐ **For the treatment of obstructive sleep apnea/hypopnea syndrome (OSAHS):**
- ☐ Has a diagnosis of OSAHS that is consistent with current International Classification of Sleep Disorders criteria (e.g., overnight PSG, out-of-center sleep testing, associated medical or psychiatric disorders, clinical assessment, etc.)
- ☐ Tried and failed continuous positive airway pressure (CPAP) while adherent to treatment to resolve daytime sleepiness demonstrated by:
  - ☐ Epworth Sleepiness Scale >10
  - ☐ Multiple sleep latency test (MSLT) <8 minutes
- ☐ Cannot use CPAP — reason: _____
  - ☐ Tried and failed an oral appliance for OSAHS to resolve daytime sleepiness

☐ **For the treatment of fatigue related to multiple sclerosis:**
- ☐ Is currently receiving treatment for MS
- ☐ Is not receiving treatment for MS — reason: _____

☐ **For a child <4 years of age:**
- ☐ Is prescribed the requested medication AND had a comprehensive evaluation by or in consultation with one of the following specialists:
  - ☐ pediatric neurologist
  - ☐ child/adolescent psychiatrist
  - ☐ child development pediatrician

INITIAL REQUESTS (continued)

☐ **For a beneficiary ≥18 years of age:**
- ☐ **For the treatment of ADHD:**
  - ☐ Has a diagnosis of ADHD that is consistent with current DSM criteria
- ☐ **For the treatment of narcolepsy:**
  - ☐ Has a diagnosis of narcolepsy consistent with current International Classification of Sleep Disorders criteria (e.g., MSLT, overnight PSG, CSF hypocretin-1 concentration, clinical assessment)
- ☐ **For the treatment of binge eating disorder:**
  - ☐ Has a diagnosis of moderate to severe binge eating disorder that is consistent with the current DSM criteria
  - ☐ Tried and failed (or cannot try) SSRIs (unless beneficiary has comorbid ADD or ADHD)
  - ☐ Tried and failed (or cannot try) topiramate (unless beneficiary has comorbid ADD or ADHD)
  - ☐ Was referred for cognitive behavioral therapy or other psychotherapy
- ☐ **For a stimulant agent:**
  - ☐ Was assessed for potential risk of misuse, abuse, and/or addiction based on family and social history
  - ☐ Was educated regarding the potential adverse effects of stimulants, including the risk of misuse, abuse, and addiction
  - ☐ Has documentation that the provider checked the PDMP for the beneficiary's controlled substance prescription history
  - ☐ **For a beneficiary with a history of substance dependency, abuse, or diversion:**
    - ☐ Has results of a recent UDS for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances

RENEWAL REQUESTS

Has the beneficiary experienced a positive clinical response since starting the requested medication?	☐ Yes	*Submit documentation*
	☐ No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: