PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **AMPHETAMINES**

BRAND NAME
(generic)

ADDERALL
(amphetamine mixture)

ADDERALL XR
(amphetamine extended-release mixture)

ADZENYS ER
(amphetamine extended-release oral suspension)

ADZENYS XR-ODT
(amphetamine extended-release orally disintegrating tablets)

DESOXYN
(methamphetamine)

DEXTROAMPHETAMINE PRODUCTS
(dextroamphetamine)

DEXEDRINE SPANSULE
(dextroamphetamine sustained-release)

DYANAVEL XR
(amphetamine extended-release oral suspension)

EVEKEO (ALL PRODUCTS)
(amphetamine sulfate)

MYDAYIS
(amphetamine mixture extended-release)

PROCENTRA
(dextroamphetamine sulfate oral solution)

VYVANSE
(lisdexamfetamine)

ZENZEDI
(dextroamphetamine)

Status: Client Requested Criteria

CRITERIA FOR APPROVAL

1	Does the patient have a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? [If no, then skip to question 3.]	Yes	No
2	Has the diagnosis been appropriately documented (i.e., evaluated by a complete clinical assessment, using DSM-5, standardized rating scales, interviews/questionnaires)? [If yes, then skip to question 11.]	Yes	No
3	Does the patient have the diagnosis of narcolepsy confirmed by a sleep study? [If yes, then skip to question 11.]	Yes	No
4	Is this request for Vyvanse for the treatment of moderate to severe binge eating disorder (BED)? [If no, then skip to question 8.]	Yes	No
5	Has the patient been receiving Vyvanse within the previous 3 months? [If yes, then skip to question 7.]	Yes	No
6	Does the patient require use of MORE than 60 capsules per month of Vyvanse 10 mg, 20 mg or 30 mg OR 30 capsules per month of Vyvanse 40 mg, 50 mg, 60 mg, or 70 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval per the Quantity Limit Chart.]	Yes	No
7	Has binge eating improved with Vyvanse treatment? [If yes, then skip to question 15.]	Yes	No
8	Does the patient have a diagnosis of idiopathic hypersomnia confirmed by polysomnography? [If yes, then skip to question 11.]	Yes	No
9	Does the patient have a diagnosis of fatigue associated with Multiple Sclerosis (MS)?	Yes	No
10	Have other causes of fatigue, tiredness, or decreased energy been evaluated and treated if necessary?	Yes	No
11	Which drug is being requested (applies to brand or generic)? [Note: Please check which drug (applies to brand or generic).] [] Adderall (amphetamine mixture) (if checked, go to 12) [] Adderall XR (amphetamine extended-release mixture) (if checked, go to 12) [] Adzenys ER (amphetamine extended-release oral suspension) (if checked, go to 12) [] Adzenys XR-ODT (amphetamine extended-release orally disintegrating tablets) (if checked, go to 12) [] Desoxyn (methamphetamine) (if checked, go to 13) [] Dexedrine Spansule (dextroamphetamine sustained-release) (if checked, go to 14) [] dextroamphetamine (if checked, go to 14) [] Dyanavel XR (amphetamine extended-release oral suspension) (if checked, go to question 12)		

[] Evekeo (amphetamine sulfate) (if checked, go to 12)
[] Evekeo ODT (amphetamine sulfate orally disintegrating tablet) (if checked, go to 12)
[] Mydayis (amphetamine extended-release mixture) (if checked, go to 12)
[] Procentra (dextroamphetamine sulfate oral solution) (if checked, go to 14)
[] Vyvanse (lisdexamfetamine) (if checked, go to question 15)
[] Zenzedi (dextroamphetamine) (if checked, go to question 14)

12	Does the patient require use of MORE than any of the following: A) 900 ml per month of Adzenys ER suspension, B) 240 ml per month of Dyanavel XR suspension, C) 180 units per month of Evekeo/Evekeo ODT 5 mg, 10 mg, D) 120 units per month of Adderall 5 mg, 7.5 mg, 10 mg, 12.5 mg OR Adderall XR 5 mg, 10mg OR Adzenys XR-ODT 3.1 mg, 6.3 mg, 9.4 mg, E) 90 units per month of Adderall 15 mg, 20 mg OR Mydayis 12.5 mg OR Evekeo ODT 15 mg, 20mg, F) 60 units per month of Adderall 30 mg OR Adderall XR 15 mg, 20 mg, 25 mg, 30 mg OR Adzenys XR-ODT 12.5 mg, 15.7 mg, 18.8 mg OR Mydayis 25 mg, G) 30 capsules per month of Mydayis 37.5 mg, 50 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval per the Quantity Limit Chart.]	Yes	No
13	Does the patient require use of MORE than 150 tablets per month of Desoxyn? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval for 150 tablets per month of Desoxyn.]	Yes	No
14	Does the patient require use of MORE than any of the following: A) 180 units per month of dextroamphetamine 5 mg, 10 mg OR Zenzedi 2.5 mg, 5 mg, 7.5 mg, 10 mg, B) 150 units per month of Dexedrine Spansule 5 mg, 10 mg, C) 120 units per month of Dexedrine Spansule 15 mg OR Zenzedi 15 mg, D) 90 units per month of Zenzedi 20 mg, E) 60 units per month of Zenzedi 30 mg, F) 1,800 ml per month of ProCentra oral solution 5 mg/5 ml? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval per the Quantity Limit Chart.]	Yes	No
15	Does the patient require use of MORE than 60 capsules per month of Vyvanse 10 mg, 20 mg or 30 mg OR 30 capsules per month of Vyvanse 40 mg, 50 mg, 60 mg, or 70 mg? [RPh Note: If yes, then deny and enter a partial approval per the Quantity Limit Chart.]	Yes	No

Mapping Instructions		
	Yes	**No**
1.	Go to 2	Go to 3
2.	Go to 11	Deny
3.	Go to 11	Go to 4
4.	Go to 5	Go to 8
5.	Go to 7	Go to 6
6.	Deny	Approve, 12 months, see Quantity Limit Chart
7.	Go to 15	Deny
8.	Go to 11	Go to 9
9.	Go to 10	Deny
10.	Go to 11	Deny
11.	1=12; 2=12; 3=12; 4=12; 5=13; 6=14; 7=14; 8=12; 9=12; 10=12; 11=12; 12=14; 13=15; 14=14	N/A
12.	Deny	Approve, 36 months, see Quantity Limit Chart

13.	Deny	Approve, 36 months, see Quantity Limit Chart
14.	Deny	Approve, 36 months, see Quantity Limit Chart
15.	Deny	Approve, 36 months, see Quantity Limit Chart

REFERENCES

1. NCSHP Prior Authorization Approval Policy.

Written by: UM Development (CT)
Date Written: 04/2017
Revised: (KC) 02/2018, (JK) 11/2019 (removed dextroamphetamine 2.5, 7.5, 15, 20, 30 mg; added Evekeo ODT)
Reviewed: Medical Affairs: (MA) 05/2017, (CW) 05/2018, 11/2019

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

_____ _____
Signature Date

_____
Client Name

Quantity for Approval - Quantity Limit Chart		
Drug	**Quantity/25 days***	**Quantity/75 days***
Adderall 5 mg, 7.5 mg, 10 mg, 12.5 mg	120 tablets	360 tablets
Adderall 15 mg, 20 mg	90 tablets	270 tablets
Adderall 30 mg	60 tablets	180 tablets
Adderall XR 5 mg, 10 mg	120 capsules	360 capsules
Adderall XR 15 mg, 20 mg, 25 mg, 30 mg	60 capsules	180 capsules
Adzenys ER oral suspension 1.25 mg/ml	900 ml	2700 ml
Adzenys XR-ODT 3.1 mg, 6.3 mg, 9.4 mg	120 tablets	360 tablets
Adzenys XR-ODT 12.5 mg, 15.7 mg, 18.8 mg	60 capsules	180 capsules
Desoxyn 5 mg	150 tablets	450 tablets
Dextroamphetamine 5 mg, 10 mg	180 tablets	540 tablets
Dexedrine Spansule 5 mg, 10 mg	150 capsules	450 capsules
Dexedrine Spansule 15 mg	120 capsules	360 capsules
Dyanavel XR oral suspension 2.5 mg/ml	240 ml	720 ml
Evekeo 5 mg, 10 mg	180 tablets	540 tablets
Evekeo ODT 5 mg, 10 mg	180 tablets	540 tablets
Evekeo ODT 15 mg, 20 mg	90 tablets	270 tablets
Mydayis 12.5 mg	90 capsules	270 capsules
Mydayis 25 mg	60 capsules	180 capsules
Mydayis 37.5 mg, 50 mg	30 capsules	90 capsules
ProCentra oral solution 5mg/5ml	1,800 ml	5,400 ml
Vyvanse 10 mg, 20 mg, 30 mg	60 capsules	180 capsules
Vyvanse 40 mg, 50 mg, 60 mg, 70 mg	30 capsules	90 capsules

Zenzedi 2.5 mg, 5 mg, 7.5 mg, 10 mg	180 tablets	540 tablets
Zenzedi 15 mg	120 tablets	360 tablets
Zenzedi 20 mg	90 tablets	270 tablets
Zenzedi 30 mg	60 tablets	180 tablets
**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*		