PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

STRATTERA
(atomoxetine hydrochloride)

Status: Client Requested Criteria
Type: Initial Prior Authorization with Quantity Limit ***Ref # C10390-C***

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 4.]	Yes	No
2	Will the patient be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior?	Yes	No
3	Does the patient require use of MORE than any of the following: A) 120 capsules per month of Strattera 10 mg, 18 mg, 25 mg, B) 60 capsules per month of Strattera 40 mg, C) 30 capsules per month of Strattera 60 mg, 80 mg, 100 mg? [No further questions.] [Rph Note: If yes, then deny and enter a partial approval for ONE of the following:) 120 capsules per month of Strattera 10 mg, 18 mg, 25 mg, B) 60 capsules per month of Strattera 40 mg, C) 30 capsules per month of Strattera 60 mg, 80 mg, 100 mg.]	Yes	No
4	Does the patient have a diagnosis of idiopathic hypersomnia confirmed by polysomnography? [If yes, then skip to question 6.]	Yes	No
5	Does the patient have a diagnosis of fatigue associated with Multiple Sclerosis (MS)?	Yes	No
6	Does the patient require use of MORE than any of the following: A) 120 capsules per month of Strattera 10 mg, 18 mg, 25 mg, B) 60 capsules per month of Strattera 40 mg, C) 30 capsules per month of Strattera 60 mg, 80 mg, 100 mg? [Rph Note: If yes, then deny and enter a partial approval for ONE of the following:) 120 capsules per month of Strattera 10 mg, 18 mg, 25 mg, B) 60 capsules per month of Strattera 40 mg, C) 30 capsules per month of Strattera 60 mg, 80 mg, 100 mg.]	Yes	No

Mapping Instructions		
	Yes	**No**
1.	Go to 2	Go to 4
2.	Go to 3	Deny
3.	Deny	Approve, 36 months: Strattera 10 mg, 18 mg, 25 mg: 120 capsules/month Strattera 40 mg: 60 capsules/month Strattera 60 mg, 80 mg, 100 mg: 30 capsules/month

CVS caremark™

4.	Go to 6	Go to 5
5.	Go to 6	Deny
6.	Deny	Approve, 12 months: Strattera 10 mg, 18 mg, 25 mg: 120 capsules/month Strattera 40 mg: 60 capsules/month Strattera 60 mg, 80 mg, 100 mg: 30 capsules/month

REFERENCES

1. NCSHP Prior Authorization Approval Policy.

Written by: UM Development (CT)
Date Written: 04/2017
Revised: (KC) 02/2018
Reviewed: Medical Affairs: (MA) 05/2017, (CW) 05/2018

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