Pharmacy Policy

ADHD medications

Policy Number: 9.505
Version Number: 2
Version Effective Date: 6/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☐ New Hampshire Medicaid	☐ MassHealth - MCO ☐ MassHealth - ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

Under the age of 25:

- **Daytrana**

25 years of age and older:

- **Amphetamine- Dextroamphetamine IR/ER**
- **Dexmethylphenidate IR/ER**
- **Dextroamphetamine IR/ER/Sol**
- **Methamphetamine**
- **Methylphenidate ER/IR/CD/LA/sol**
- **Daytrana**
- **Quillichew ER**
- **Quillivant XR**
- **Vyvanse**

The Plan may authorize coverage of the above products for members meeting the following criteria:

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Covered Use	All FDA approved indications not otherwise excluded
Exclusion Criteria	None
Required Medical Information	**Amphetamine-Dextroamphetamine IR/ER, Dexmethylphenidate IR/ER, Dextroamphetamine IR/ER/Sol, Methamphetamine, Methylphenidate ER/IR/CD/LA/ Sol** 1. Documentation of diagnosis of one of the following: a. A diagnosis of ADHD before the age of 12 b. Narcolepsy c. Depressive condition in which the stimulant will be used as an augmenting agent with concomitant antidepressant medication; **OR** 2. Provider attestation that there was evidence of signs and symptoms of ADHD before the age of 12 years; **OR** 3. Member has excessive daytime sleepiness associated with multiple sclerosis, chronic fatigue syndrome, obstructive sleep apnea , depression **Vyvanse:** 1. Documentation of diagnosis of one of the following: a) A diagnosis of ADHD before the age of 12 b) Narcolepsy c) Depressive condition in which the stimulant will be used as an augmenting agent with concomitant antidepressant medication; OR 2. Provider attestation that there was evidence of signs and symptoms of ADHD before the age of 12 years; OR 3. Member has excessive daytime sleepiness associated with multiple sclerosis, chronic fatigue syndrome, obstructive sleep apnea or depression; OR 4. A diagnosis of Binge Eating Disorder **Daytrana (PA applicable for both under and over age 25 years old), Qullichew ER, Quillivant XR** 1. A diagnosis of ADHD; ***AND*** 2. An inadequate response to at least a 30-day trial of two long acting generic stimulants (See Appendix A); ***OR*** 3. Clinical difficulty swallowing tablets or capsules; ***and*** inability to use opened capsules due to a clinical reason
Age Restriction	None

Prescriber Restriction	None
Coverage Duration	12 months
Other criteria	None

Appendix A:

Amphetamine-Dextroamphetamine ER
Dexmethylphenidate ER
Methylphenidate ER/CD/LA/

Clinical Background Information and References

1. Krull KR. Attention Deficit Hyperactivity Disorder in Children and Adolescents: Treatment with Medications. UpToDate®. Accessed Aug 2013.
2. McVoy M, Findling R. Child and Adolescent Psychopharmacology Update. Psychiatr Clin N Am 32 (2009):111-133.
3. Pliszka S, AACAP Work Group. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder. J Am Acad Child Adolesc Psychiatry 2007;46(7):894-921.
4. Searight HR, Burke JM. Adult attention deficit hyperactivity disorder. UpToDate®.Updated Feb 2011. Accessed Aug 2012.
5. Wigal SB, Chae S, Patel A. Advances in the Treatment of Attention-Deficit/HyperactivityDisorder: A Guide for Pediatric Neurologists. Semin Pediatr Neurol 2010;17:230-236.
6. Prescribing Information. Daytrana® (methylphenidate transdermal system). NovenPharmaceuticals, Inc., Miami, FL 33186. Nov 2010.
7. Prescribing Information. Intuniv™ (guanfacine extended-release). Shire US Inc., Wayne,PA 19087. June 2011.
8. Prescribing Information. Kapvay™ (clonidine hydrochloride extended-release). ShionogiPharma, Inc., Atlanta, GA 30328. Sept 2010.
9. Prescribing Information. Strattera® (atomoxetine hydrochloride). Eli Lilly and Co.,Indianapolis, IN 46285. March 2011.
10. Prescribing Information. Vyvanse® (lisdexamfetamine dimesylate). Shire US Inc., Wayne,PA 19087. March 2011.
11. Brent D. Pharmacotherapy for Adult ADHD. UpToDate®. Accessed Aug 2013.
12. Prescribing Information. Zenzedi®(dextroamphetamine sulfate). Arbor Pharmaceuticals, LLC, Atlanta, GA 30328. January 2014
13. Prescribing Information. Concerta (methylphenidate OSM). Titusville, NJ: Janssen; December 2013.
14. Prescribing Information. Aptensio XR (methylphenidate) extended-release capsules. Greenville, NC: Patheon; April 2015.

15. Dyanavel XR (amphetamine) [prescribing information]. Monmouth Junction, NJ: Tris Pharma; November 2015.
16. Evekeo (amphetamine) [prescribing information]. Atlanta, GA: Arbor Pharmaceuticals LLC; April 2014.

Adzenys XR-ODT (amphetamine) [prescribing information]. Grand Prairie, TX: Neos Therapeutics; January 2016

Original Approval Date	Original Effective Date	Policy Owner	Approved by
9/10/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
9/10/2020	P&T Annual Review: 9.160 ADHD policy (QHP) retired, new policy created;moved clonidine ER to covered;moved Adzenys, Aptensio, Cotempla, Dyanavel, Mydayis, Quillichew and Quillivant to non preferred; slightly updated criteria for Daytrana; added Amphetamine-Dextroamphetamine IR/ER, Dexmethylphenidate IR/ER, Dextroamphetamine IR/ER/Sol, Methamphetamine, Methylphenidate ER/IR/CD//LA/sol and Vyvanse to policy; updated initial approval from 24 months to 12 months	1/1/2021	P&T Committee
2/11/2021	Quillichew ER and Quillivant XR added to policy	6/1/2021	P&T Committee

Next Review Date

2/2022

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.