




# Medical Assistance BULLETIN

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| <b>ISSUE DATE</b><br>November 13, 2024                                                            | <b>EFFECTIVE DATE</b><br>January 6, 2025 | <b>NUMBER</b><br>*See below                                                                                                                                                  |
| <b>SUBJECT</b><br><br>Prior Authorization of Stimulants and Related Agents –<br>Pharmacy Services |                                          | <b>BY</b><br><br>Sally Kozak<br>Deputy Secretary<br>Office of Medical Assistance Programs |

**IMPORTANT REMINDER:** All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: <https://www.pa.gov/en/agencies/dhs/resources/providers/provider-enrollment-information/provider-enrollment-documents.html>.

## **PURPOSE:**

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Stimulants and Related Agents submitted for prior authorization.

## **SCOPE:**

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Stimulants and Related Agents will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Stimulants and Related Agents to the appropriate managed care organization.

## **BACKGROUND/DISCUSSION:**

The Department of Human Services (Department) is updating the medical necessity guidelines for Stimulants and Related Agents as follows:

- Revision of the guideline for non-preferred Stimulants and Related Agents, except an analeptic agent, to consider therapeutically equivalent brands and generics.

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| *01-25-29 | 09-25-29 | 27-25-29 | 33-25-29 |
| 02-25-29  | 11-25-29 | 30-25-29 |          |
| 03-25-29  | 14-25-29 | 31-25-29 |          |
| 08-25-30  | 24-25-29 | 32-25-29 |          |

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

Fee-for-Service Provider Service Center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:  
<https://www.pa.gov/en/agencies/dhs/departments-offices/omap-info.html>

- Deletion of the guidelines related to documentation that the prescriber or prescriber's delegate conducted a search of the Prescription Drug Monitoring Program.
- Addition of a guideline to the requests for renewal of the prior authorization section related to requests for non-preferred Stimulants and Related Agents, except an analeptic agent, with a therapeutically equivalent brand or generic that is preferred on the Preferred Drug List.
- Addition of a guideline to the requests for renewal of the prior authorization section related to requests for non-preferred analeptic Stimulants and Related Agents.

There are no other changes to the medical necessity guidelines.

The revisions to the guidelines to determine medical necessity of prescriptions for Stimulants and Related Agents were subject to public review and comment and subsequently approved for implementation by the Department.

#### **PROCEDURE:**

The procedures for prescribers to request prior authorization of Stimulants and Related Agents are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Stimulants and Related Agents) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs and products that require prior authorization.

#### **ATTACHMENTS:**

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

#### **RESOURCES:**

Prior Authorization of Pharmaceutical Services Handbook – SECTION I  
Pharmacy Prior Authorization General Requirements

<https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements.html>

Prior Authorization of Pharmaceutical Services Handbook – SECTION II  
Pharmacy Prior Authorization Guidelines

<https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/clinical-guidelines.html>

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**I. Requirements for Prior Authorization of Stimulants and Related Agents**

**A. Prescriptions That Require Prior Authorization**

Prescriptions for Stimulants and Related Agents that meet the following conditions must be prior authorized.

1. A non-preferred Stimulants and Related Agent. See the Preferred Drug List (PDL) for the list of preferred Stimulants and Related Agents at: <https://papdl.com/preferred-drug-list>.
2. A Stimulants and Related Agent with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: <https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html>.
3. A Stimulants and Related Agent for a beneficiary under four years of age.
4. A prescription for an analeptic Stimulants and Related Agent (e.g., armodafinil, modafinil, etc.).
5. A Stimulants and Related Agent when there is a record of a recent paid claim for another Stimulants and Related Agent with the same duration of action (i.e., short-acting or long-acting) in the point-of-sale online claims adjudication system (therapeutic duplication).  
EXCEPTIONS: Intuniv (guanfacine ER), Kapvay (clonidine ER), an analeptic Stimulants and Related Agent.
6. A Stimulants and Related Agent when prescribed for a beneficiary 18 years of age or older.  
EXCEPTION: An analeptic Stimulants and Related Agent.

**B. Review of Documentation for Medical Necessity**

In evaluating a request for prior authorization of a prescription for a Stimulants and Related Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For Evekeo (amphetamine) for the treatment of obesity, see the prior authorization guideline related to Obesity Treatment Agents; **OR**
2. For a non-preferred Stimulants and Related Agent, except an analeptic agent, **one** of the following:
  - a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Stimulants and Related Agents approved or medically accepted for the beneficiary's diagnosis

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

- b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Stimulants and Related Agent (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred);

**AND**

- 3. For an analeptic Stimulants and Related Agent, all of the following:
  - a. Is not receiving concurrent treatment with sedative hypnotics,
  - b. Is prescribed the analeptic Stimulants and Related Agent for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,
  - c. For the treatment of narcolepsy and shift work sleep disorder, has a diagnosis confirmed according to the most recent consensus treatment guidelines (e.g., American Academy of Sleep Medicine International Classification of Sleep Disorders),
  - d. For the treatment of obstructive sleep apnea/hypopnea syndrome (OSAHS), has **both** of the following:
    - i. A diagnosis of OSAHS confirmed according to the most recent consensus treatment guidelines (e.g., American Academy of Sleep Medicine International Classification of Sleep Disorders)
    - ii. A history of therapeutic failure of continuous positive airway pressure (CPAP) to resolve excessive daytime sleepiness (documented by either Epworth Sleepiness Scale greater than 10 or multiple sleep latency test (MSLT) less than eight minutes) with documented compliance to CPAP treatment or, if the beneficiary has a medical reason CPAP cannot be used, therapeutic failure of an oral appliance for OSAHS,
  - e. For the treatment of multiple sclerosis-related fatigue, is receiving treatment for multiple sclerosis or, if not being treated, the medical record documents the rationale for the beneficiary not being treated,
  - f. For a non-preferred analeptic Stimulants and Related Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred analeptic Stimulants and Related Agents approved or medically accepted for the beneficiary's diagnosis;

**AND**

- 4. For a beneficiary under four years of age, **all** of the following:

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

- a. Is prescribed the Stimulants and Related Agent for an indication that is included in the FDA-approved package labeling OR a medically accepted indication,
- b. Is being prescribed the drug by or in consultation with **one** of the following:
  - i. Pediatric neurologist,
  - ii. Child and adolescent psychiatrist,
  - iii. Child development pediatrician,
- c. Has chart-documented evidence of a comprehensive evaluation by or in consultation with a specialist listed above;

**AND**

- 5. For a beneficiary 18 years of age or older, **all** of the following:
  - a. Is prescribed the Stimulants and Related Agent for an indication that is included in the FDA-approved package labeling OR a medically accepted indication,
  - b. For the treatment of attention deficit hyperactivity disorder (ADHD), has a diagnosis of ADHD as documented by a history consistent with the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria,
  - c. For the treatment of moderate to severe binge eating disorder, **all** of the following:
    - i. Has a diagnosis documented by a history that is consistent with the current DSM criteria,
    - ii. In the absence of a diagnosis of ADHD or attention deficit disorder, has a documented history of therapeutic failure of or a contraindication or an intolerance to selective serotonin reuptake inhibitors or topiramate,
    - iii. Has documentation of a referral for cognitive behavioral therapy or other psychotherapy,
  - d. For the treatment of narcolepsy, has a diagnosis confirmed according to the most recent consensus treatment guidelines (e.g., American Academy of Sleep Medicine International Classification of Sleep Disorders),
  - e. For a Stimulant Agent, **both** of the following:
    - i. Was assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescribing provider
    - ii. Has documentation that the beneficiary has been educated on the potential adverse effects of stimulants, including the risk for misuse, abuse, and addiction,
  - f. For a Stimulant Agent for a beneficiary with a history of comorbid substance

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

dependency, abuse, or diversion, has results of a recent urine drug screen testing 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;

**AND**

6. For therapeutic duplication, **one** of the following:
  - a. Is being transitioned to another Stimulants and Related Agent with the same duration of action (i.e., short-acting or long-acting) with the intent of discontinuing one of the drugs
  - b. Supporting peer-reviewed medical literature or national treatment guidelines corroborate concomitant use of the drugs being requested;

**AND**

7. If a prescription for a Stimulants and Related Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

**FOR RENEWALS OF PRIOR AUTHORIZATION FOR A STIMULANTS AND RELATED AGENT:** The determination of medical necessity of a request for renewal of a prior authorization for a Stimulants and Related Agent that was previously approved will take into account whether the beneficiary:

1. Has documentation of a positive clinical response to the drug; **AND**
2. For a non-preferred Stimulants and Related Agent, except an analeptic agent, with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug; **AND**
3. For a non-preferred analeptic Stimulants and Related Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred analeptic Stimulants and Related Agents approved or medically accepted for the beneficiary's diagnosis; **AND**
4. For therapeutic duplication, **one** of the following:
  - a. Is being transitioned to another Stimulants and Related Agent with the same duration of action (i.e., short-acting or long-acting) with the intent of discontinuing one of the drugs

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

- b. Supporting peer-reviewed medical literature or national treatment guidelines corroborate concomitant use of the drugs being requested;

**AND**

5. If a prescription for a Stimulants and Related Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

**C. Clinical Review Process**

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Stimulants and Related Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

All requests for prior authorization of a prescription for a Stimulants and Related Agent for a Medical Assistance beneficiary under four years of age will be automatically forwarded to a physician reviewer (a psychiatrist) for a medical necessity determination. The physician reviewer (a psychiatrist) will consider the guidelines in Section B. above and will approve the request when, in the professional judgment of the physician reviewer (a psychiatrist), the services are medically necessary to meet the medical needs of the beneficiary.

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MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

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