AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Non-Preferred Central Nervous System (CNS) Stimulants (For all ages)

- **A review of written documentation to substantiate a complete, appropriate, and covered diagnosis for both new starts and members currently receiving any CNS stimulant listed below will be required before Prior Authorization approval**. **Prescribing history alone WILL NOT meet criteria for approval.**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

❑ Request is being submitted for **BRAND** ❑ Request is being submitted for **GENERIC**

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- Will the member be discontinuing a previously prescribed central nervous system (CNS) stimulant medication if approved for requested medication?

  ❑ Yes **OR** ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

(Continued on next page)

DRUG(S) REQUESTED: Check applicable drug(s) below. Box(es) **must** be checked to qualify, or authorization process will be delayed.

❑ **Adhansia XR®**	❑ **Adzenys XR-ODT®** ❑ **Adzenys ER® Suspension**	❑ **amphetamine ER ODT** (Adzenys XR ABA)
❑ **amphetamine sulfate** (Evekeo®)	❑ **Azstarys®**	❑ **Cotempla XR-ODT**
❑ **Dyanavel® XR Suspension** ❑ **Dyanavel® XR Chewable Tablets**	❑ **Evekeo ODT®**	❑ **Jornay PM®**
❑ **methylphenidate ER** (Aptensio XR®)	❑ **methylphenidate TD Patch** (Daytrana®)	❑ **Mydayis®**
❑ **Quillichew® ER**	❑ **Quillivant XR®**	❑ **Xelstrym™** (dextroamphetamine)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Member must have tried and failed **30 days of therapy** with **three (3)** of the following generic stimulant medications – medication trial **MUST** include an amphetamine-based stimulant **AND** a methylphenidate-based stimulant **(verified by chart notes and/or pharmacy paid claims)**:

Amphetamine-based stimulants: (select all that apply)

- ❑ amphetamine-dextroamphetamine IR/ER (generic Adderall/Adderall XR®)
- ❑ dextroamphetamine IR/SR (generic Dextrostat®/Procentra®/Zenzedi®/Dexedrine® IR/ER)
- ❑ lisdexamfetamine (generic Vyvanse®)

Methylphenidate-based stimulants: (select all that apply)

- ❑ dexmethylphenidate IR/ER (generic Focalin®/Focalin XR®)
- ❑ methylphenidate IR/ER (generic Ritalin®/Methylin®/Ritalin SR®/Ritalin LA®/Concerta®/ Metadate CD®/Metadate ER®

❑ If the member is **over the age of 18**, member **must** also meet diagnostic criteria. The prior authorization form "CNS Stimulants for Adults Age 19 and Above" can be downloaded from: **https://www.avmed.org/forms/provider/**

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee:** ~~2/15/2018; 9/15/2022; 2/17/2023; 7/24/2025;~~ **9/25/2025**
REVISED/UPDATED/REFORMATTED: ~~2/19/2018; 6/25/2018; 6/3/2019; 8/13/2019; 12/7/2020; 9/10/2021, 11/8/2021' 11/22/2021; 11/7/2022; 3/2/2023; 7/01/2024; 8/18/2025;~~ **10/24/2025**