BEHAVIORAL HEALTH & RECOVERY SERVICES

SAN MATEO COUNTY

PRIOR AUTHORIZATION PROCEDURES

11/28/2018

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SAN MATEO COUNTY

Prior Authorization Procedures

Drug products, which are listed as **Prior Authorization (PA) required**, require approval when the member presents a prescription to a network pharmacy. To obtain coverage a pharmacist or physician may:

Fax a completed **Prior Authorization Request** to Health Plan of San Mateo (HPSM) Fax: 650-829-2045.

The request will be reviewed by BHRS staff according to Prior Authorization criteria approved by the BHRS P & T Committee.

If the request meets established criteria, the request will be approved and an authorization given.

If the request does not meet the criteria established by the P & T Committee, the request will be denied.

Failure to submit a Prior Authorization for a listed drug will result in a denial of coverage for the health plan member.

LEGEND	
TYPE	DESCRIPTION
PA	Prior Authorization
QL	Quantity Limit
DS	Day Supply
IR	Immediate Release
ER/XR	Extended Release
ODT	Oral Dissolving Tablet
CR	Controlled Release

ANXIOLYTICS

Drug Name Brand Generic	 Xanax **Alprazolam**
Covered Uses	All medically accepted indications
Required Medical Information	1. Patient has tried and failed, has an allergic reaction or contraindication to Step 2 medications (see Benzodiazepines Guidelines below), and 2. Patient has tried and failed formulary benzodiazepines Lorazepam and Clonazepam.
Age Restriction	
Prescriber Restriction	
Other Restriction	Approved up to FDA Max dose
Coverage Duration	Approved for up to 12 months
Other Criteria	See Benzodiazepines Guidelines below Obtain CURES report

Drug Name Brand Generic	 Xanax XR **Alprazolam XR**
Covered Uses	All medically accepted indications
Required Medical Information	1.Patient has tried and failed Step 2 medications (see Benzodiazepines Guidelines below), and 2.Patient has tried and failed formulary Lorazepam and Clonazepam, and 3. Patient has responded to generic Alprazolam in the past and demonstrates noncompliance, side effects, intolerance to generic Alprazolam.
Age Restriction	
Prescriber Restriction	
Other Restriction	Approved up to FDA Max dose
Coverage Duration	Approved for up to 12 months
Other Criteria	See Benzodiazepines Guidelines below Obtain CURES report

Drug Name Brand Generic	 Valium **Diazepam**
Covered Uses	All medically accepted indications
Required Medical Information	1. Patient has tried and failed, has an allergic reaction or contraindication to Step 2 medications (see Benzodiazepines Guidelines below), and 2. Patient has tried and failed formulary benzodiazepines Lorazepam and Clonazepam.
Age Restriction	
Prescriber Restriction	
Other Restriction	Approved up to FDA Max dose
Coverage Duration	Approved for up to 12 months
Other Criteria	See Benzodiazepines Guidelines below Obtain CURES report

Drug Name Brand Generic	 Ativan Injectable **Lorazepam Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	Patient unable to take oral form of this medication
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 3 months
Other Criteria	

BENZODIAZEPINES GUIDELINES

Benzodiazepines (BZ) are very effective for **insomnia and anxiety disorders**. However, the use of BZ should be cautious because of their high risk of abuse, dependence, severe withdrawal symptoms, and cognitive impairment. In general, BZ should be considered last after other non-BZ treatment measures have failed. Moderately short-acting BZ are preferred than ultra-short-acting and long-acting BZ. The duration time to use BZ for symptomatic treatment of insomnia and anxiety disorders should be limited to 3-4 weeks. However, some patients with chronic symptoms of anxiety disorders may need long-term treatment BZ to have productive and comfortable lives.

Proposed steps to consider before treatment with Benzodiazepines:

Step 1: No medications

- Sleep hygiene: Walks after dinner, warm milk, warm bath or shower, quiet environment, soothing music…
- Cognitive behavioral therapy, yoga, meditation, relaxation breathing techniques…

Step 2: With no known abuse potential

Insomnia:

- Trazodone usually 25-50mg q HS, but up to 100-200mg
- Hydroxyzine or Diphenhydramine usually 25-50mg q HS, but up to 100-150mg
- TCA such as Amitriptyline or Doxepine 10-50mg q HS
- Rozerem 8mg q HS or Melatonin 0.3 – 5mg q HS, esp for elderly

Anxiety Disorders or MDD+Anxiety sx should consider monotherapy or combination of

- SSRIs, SNRIs, Buspirone, Beta-blockers, Mirtazapine, Trazodone, Bupropion. TCAs.

Step 3: Non-benzodiazepines

- Zolpidem (Ambien) 5-10mg q HS.
- Zaleplon (Sonata) 5-10mg q HS.
- Eszopicolone (Lunesta) 1-3mg q HS.

Step 4: Benzodiazepines (BZ).

- Moderately short acting BZ should be considered to minimize accumulation and sedation. Recommend to use less than 3-4 weeks.
- Temazepam (Restoril) 7.5-15mg q HS for insomnia only.
- Lorazepam (Ativan) 0.5-2mg q day for insomnia and anxiety
- Clonazepam (Klonopin) 0.5mg-2mg q d for insomnia and anxiety.

- Ultra-short acting BZ such as Triazolam (Halcion) should be avoided because of side effects of memory impairment, withdrawal psychosis, and confusion.
- Long-acting BZ such as Diazepam (Valium), Flurazepam (Dalman) should be used cautiously because of cumulative effects that may cause drowsiness, risks of fall, and cognitive impairment especially in elderly patients.
- Alprazolam (Xanax) has high abuse risk.

ANTIDEPRESSANTS

Drug Name Brand Generic	 Paxil CR **Paroxetine Controlled Release**
Covered Uses	All medically accepted indications
Required Medical Information	Patient has tried and failed regular Paroxetine, or has had a positive response to this drug in the past.
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	

Drug Name Brand Generic	 Emsam Patch **Selegiline Transdermal**
Covered Uses	All medically accepted indications
Required Medical Information	Patient has tried and failed two formulary antidepressants or Patient cannot tolerate or is noncompliant with oral medications
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	

Drug Name Brand Generic	 Viibryd **Vilazodone**
Covered Uses	All medically accepted indications
Required Medical Information	Documentation required to indicate that patient has tried and failed at least two trials of formulary antidepressants
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Trintellix **Vortioxetine**
Covered Uses	All medically accepted indications
Required Medical Information	Documentation required to indicate that patient has tried and failed at least two trials formulary antidepressants
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

ANTIPARKINSON AGENTS

Drug Name Brand Generic	 Cogentin Injectable **Benztropine Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	Patient unable to take oral form of this medication
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 3 months
Other Criteria	

Drug Name Brand Generic	 Parlodel **Bromocriptine**
Covered Uses	All medically accepted indications
Required Medical Information	Patient has tried and failed a formulary antiparkinson agent, or has contraindication to formulary antiparkinson agent, or has had a positive response to this drug in the past, or is being treated for drug-induced sexual side effects.
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Benadryl Injectable **Diphenhydramine Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	Patient is unable to take oral form of this medication
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 3 months
Other Criteria	

ANTIPSYCHOTICS

Drug Name Brand Generic	 Abilify Discmelt, Injectable, Oral solution **Aripiprazole ODT, Injectable, Oral solution**
Covered Uses	All medically accepted indications
Required Medical Information	Discmelt or oral solution: unable to tolerate or noncompliant with oral tablet, approve up to 12 months Injectable: unable to tolerate or noncompliant with oral formulations, approve up to 3 months BRAND: tried and failed generic, approve up to 12months Abilify Maintena or Aristada: see separate approval criteria
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #30/30DS for oral tabs and discmelt; may override QL during titration up to 3 months
Coverage Duration	Approved for ODT, BRAND, oral solution, all strengths up to 12 months Approved for Injectable or QL up to 3 months
Other Criteria	

Drug Name Brand Generic	 Abilify Maintena or Aristada **Aripiprazole Long-Acting Injectable**
Covered Uses	All FDA approved indications
Required Medical Information	Documentation to indicate patient has tried and failed oral antipsychotic therapy Or Transferred from hospital/facility/another provider stabilized on this medication
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #1 per 28DS for Abilify Maintena QL exception requires documentation to indicate both: a. Gluteal injection has been tried or offered b. Higher dosage strength has been tried or offered
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Aristada Initio® **Aripiprazole Lauroxil NanoCrystal Dispersion Technology**
Covered Uses	All medical accepted indications
Required Medical Information	Patient has history of noncompliance with oral antipsychotics or difficulty in swallowing oral medications
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved one dose of Aristada Initio with oral Aripiprazole
Other Criteria	

Drug Name Brand Generic	 Saphris **Asenapine**
Covered Uses	All medical accepted indications
Required Medical Information	Documentation required to indicate that patient has tried and failed two trials of formulary antipsychotics
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #60/30DS
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Rexulti **Brexpiprazole**
Covered Uses	All medical accepted indications
Required Medical Information	Schizophrenia: tried and failed two formulary antipsychotics Major depression: tried and failed one generic atypical antipsychotics, used in adjunct with antidepressant
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #30/30DS
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Vraylar **Cariprazine**
Covered Uses	All medically accepted indications
Required Medical Information	Tried and failed two formulary antipsychotics
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #30/30DS
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Fazaclo or Versacloz **Clozapine ODT or Oral solution**
Covered Uses	All medically accepted indications
Required Medical Information	Fazaclo or Versacloz: unable to tolerate or noncompliant with oral tablet BRAND Clozapine: tried and failed generic
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Adasuve **Loxapine Inhalation**
Covered Uses	All medically accepted indications
Required Medical Information	Documentation required to indicate enrollment into Adasuve REMS Program
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = one dose per 24 hours
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Fanapt **Iloperidone**
Covered Uses	All medically accepted indications
Required Medical Information	Documentation required to indicate that patient has tried and failed two trials formulary antipsychotics
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #60/30DS
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Zyprexa Injectable, Oral solution, Zydis **Olanzapine Injectable, ODT, Oral solution**
Covered Uses	All medically accepted indications
Required Medical Information	ODT or oral solution: unable to tolerate or noncompliant with oral tablet, approve up to 12 months Injectable: unable to tolerate or noncompliant with oral formulations, approve up to 3 months BRAND: tried and failed generic, approve up to 12months Zelprev: Non-formulary, not approvable. Consult with medical director
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #30/30DS *(all strengths EXCEPT 15mg)* QL = #60/30DS *(15mg)* May override QL during titration for up to 3 months
Coverage Duration	Approved for ODT(QL), Brand (QL), oral solution, all strengths up to12 months; Approved for Injectable, QL up to 3 months
Other Criteria	

Drug Name Brand Generic	 Invega ER Oral **Paliperidone ER**
Covered Uses	All medically accepted indications
Required Medical Information	Invega oral: documentation required to indicate patient has tried and failed oral Risperidone BRAND: tried and failed generic, approve up to 12months Invega Sustenna/Trinza: see separate approval criteria
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Invega Sustenna **Paliperidone Long-Acting Injectable**
Covered Uses	All FDA approved indications
Required Medical Information	Documentation to indicate patient has tried and failed oral antipsychotic therapy Or Transferred from hospital/facility/another provider stabilized on this medication
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #1/28DS *(all strengths)* QL exception requires documentation to indicate both: a. Gluteal injection has been tried or offered b. Higher dosage strength has been tried or offered
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Invega Trinza **Paliperidone Long-Acting Injectable**
Covered Uses	All FDA approved indications
Required Medical Information	Treatment with Invega Sustenna for at least 4 months, with last 2 doses of Invega Sustenna being the same dosage strength before starting Invega Trinza. Use dosage conversion chart for Trinza dose. If more frequent dosing than Q3month is requested, gluteal injection will be required
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #1/84DS *(all strengths)* QL exception requires documentation to indicate both: c. Gluteal injection has been tried or offered d. Higher dosage strength has been tried or offered
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Seroquel **Quetiapine**
Covered Uses	All medically accepted indications
Required Medical Information	Brand Quetiapine: tried and failed generic
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #90/30DS for IR QL = #30/30DS for ER *(150mg,200mg,300mg)* QL = #60/30DS for ER *(50mg)* QL = #90/30DS for ER *(400mg)*
Coverage Duration	Approved for QL, all strengths brand, up to 12 months
Other Criteria	

Drug Name Brand Generic	 Risperdal M-tab or Oral solution **Risperidone ODT or Oral solution**
Covered Uses	All medically accepted indications
Required Medical Information	ODT or oral solution: unable to tolerate or noncompliant with oral tablet Brand: tried and failed generic Risperdal Consta: see separate approval criteria
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Risperdal Consta **Risperidone Long-Acting Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	Patient has history of noncompliance with oral antipsychotics or difficulty in swallowing oral medications Or Transferred from hospital/facility/another provider stabilized on this medication
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #1/14DS *(all strengths)*
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Perseris® **Risperidone Subcutaneous Long-Acting Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	History of noncompliance with oral antipsychotics or difficulty in swallowing oral medications
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = 90mg or 120mg per 28DS
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Geodon **Ziprasidone**
Covered Uses	All medically accepted indications
Required Medical Information	Oral solution: unable to tolerate or noncompliant with oral tablet, approve up to 12 months Brand Ziprasidone: tried and failed generic Injectable: unable to tolerate or noncompliant with oral formulations, approve up to 3 months
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for Oral solution, all strengths brand, up to 12 months Approved for Injectable for up to 3 months
Other Criteria	

ADHD MEDICATIONS

Drug Name Brand Generic	 Adderall **Amphetamine-Dextroamphetamine IR**
Covered Uses	FDA approved indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 3. Urine Tox screen (see Criteria below)
Age Restriction	Restricted to ADD/ADHD between ages 4-21 PA required for age >21
Prescriber Restriction	none
Other Restriction	QL = #90/30DS *(5mg,7.5mg,10mg,12.5mg,15mg,20mg)* QL = #60/30DS *(30mg)* Approved up to FDA Max dose
Coverage Duration	Variable depending on criteria below
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6 months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2 above

Drug Name Brand Generic	 Focalin IR, XR **Dexmethylphenidate IR, XR**
Covered Uses	FDA approved indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 3. Urine Tox screen (see Criteria below) 4. Patient has tried and failed two formulary stimulants, or has had a positive response to this drug in the past
Age Restriction	6 years and older
Prescriber Restriction	none
Other Restriction	QL = #90/30DS for IR *(2.5mg,5mg,10mg)* QL = #30/30DS for XR *(5mg,10mg,15mg,20mg,25mg,30mg,35mg,40mg)* Approved up to FDA Max dose
Coverage Duration	For IR, see other Criteria below Approved XR for 12 months;
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines. 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6 months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2 above

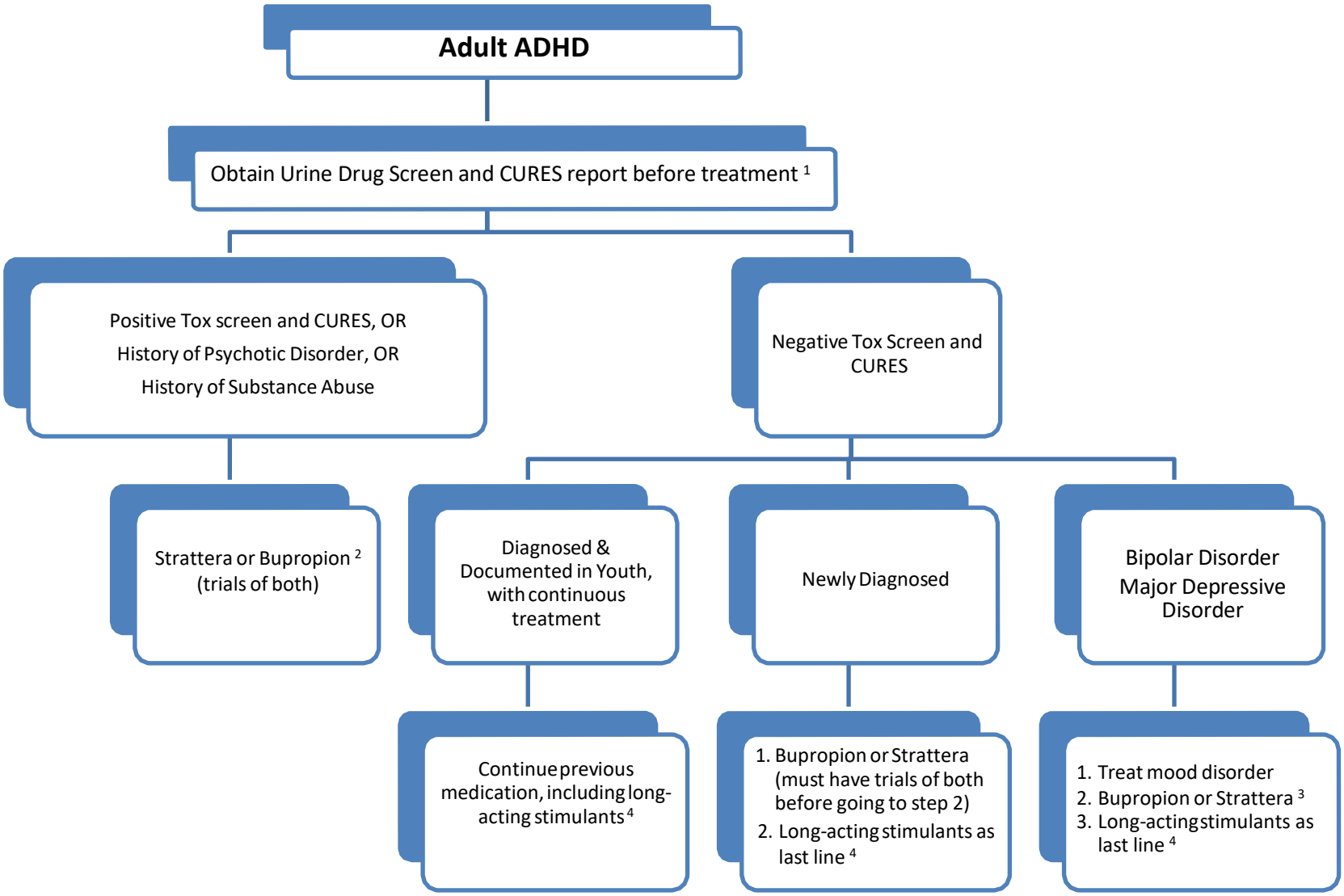
Drug Name Brand Generic	 Dexedrine **Dextroamphetamine**
Covered Uses	FDA approved indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 3. Urine Tox screen (see Criteria below)
Age Restriction	Restricted to ADD/ADHD between ages 4-21 PA required for age >21
Prescriber Restriction	none
Other Restriction	QL = #120/30DS *(5mg,10mg)* Approved up to FDA Max dose
Coverage Duration	Variable depending on criteria below
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines. 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6 months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2 above

Drug Name Brand Generic	 Desoxyn **Methamphetamine**
Covered Uses	All medically accepted indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Tried and failed two formulary stimulants 3. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 4. Urine Tox screen (see Criteria below)
Age Restriction	Restricted to ADD/ADHD between ages 4-21 PA required for age >21
Prescriber Restriction	none
Other Restriction	QL = #90/30DS Approved up to FDA Max dose
Coverage Duration	Variable depending on criteria below
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines. 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6 months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2 above

Drug Name Brand Generic	 Ritalin **Methylphenidate IR**
Covered Uses	FDA approved indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 3. Urine Tox screen (see Criteria below)
Age Restriction	Restricted to ADD/ADHD between ages 4-21 PA required for age >21
Prescriber Restriction	none
Other Restriction	QL = #90/30DS for IR *(5mg,10mg,20mg)* Approved up to FDA Max dose
Coverage Duration	Variable depending on criteria below
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines. 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2 above

San Mateo County Health System
Behavioral Health & Recovery Services

Adult ADHD Treatment Guidelines



1 Obtain random Urine Drug Screen and regular CURES reports during treatment
2 Trials of both Strattera and Bupropion are recommended, consider using Clonidine or Guanfacine as alternatives
3 For other treatment options, please refer to Bond et al. (2012) article: http://www.aacp.com/pdf%2F0212%2F0212ACP_Bond.pdf
4 Use long-acting stimulants to minimize diversion

Rev. 01.2016

Stimulant medication maximum dose for adults					
Drug	**Range**	**FDA max**	**SF county**	**SC county**	**BHRS**
Amphetamines					
Evekio (IR)	5-60mg/day for obesity every 4-6 hrs		40mg		40mg*
	Only in rare cases will it be necessary to exceed 40 mg daily in ADHD				
Adzensys XR or Dyanavel XR	12.5-20mg/day in ADHD, 10-60mg/day in Narcolepsy	20mg	20mg		20mg
Amphetamine salts					
Adderall IR	5-40mg/day for ADHD; 5-60mg/day for narcolepsy Q4-6hrs	rarely necessary to exceed 40mg/	40mg	40mg	40mg
Adderall XR	start with 20mg/day, up to 60mg/day evaluated with? benefit	30mg in peds	30mg	60mg	60mg*
Mydayis (ER lasting 16 hrs)	12.5-50mg/day	50mg			
Dexmethylphenidate					
Focalin IR	5-20mg/day	20mg	20mg	20mg	20mg
Focalin ER	10-40mg/day	40mg	40mg	40mg	40mg
Dextroamphetamine					
Zenzedi or Dexedrine IR	5-60mg/day in 2-3 divided doses for narcolepsy	40mg in peds	40mg	60mg	60mg*
Dexedrine SR	5-60mg QD for narcolepsy	40mg in peds	40mg	60mg	60mg*
	Dosages up to 0.9 mg/kg daily but rarely exceeding 40 mg daily.				
Lisdexamfetamine					
Vyvanse	30-70mg/day	70mg		70mg	70mg
Methamphetamine					
Desoxyn	*Methamphetamine has a high potential for abuse.	* 25mg in peds		25mg	25mg*
The drug should be prescribed or dispensed sparingly and attention should be paid to the possibility of subjects obtaining methamphetamine for non-therapeutic use or distribution to others					
Methylphenidate					
IR	10-60mg/day in 2-3 divided doses	60mg	60mg	60mg	60mg
Aptensio XR	10-60mg/day	60mg	60mg	60mg	60mg
Concerta	18-72mg/day	72mg	72mg		72mg
Metadate CD	20-60mg/day	60mg	60mg	60mg	60mg
Quillichew ER	20-60mg/day	60mg	60mg	60mg	60mg
Ritalin LA	10-60mg/day	60mg	60mg	60mg	60mg
Ritalin SR	20-60mg/day divided every 8 hours	60mg	60mg	60mg	60mg
Daytrana patch	10-30mg/day	30mg	30mg	30mg	30mg
Ref: AHFS DI, Micromedex, Facts&Comparisons, Lexi-Drugs, accessed 10/4/2017					
* Max dose determined by P&T committee after reviewing FDA dosing range and SF/SC county guidelines					
P&T 10/11/2017					

HYPNOTICS

Drug Name Brand Generic	 Belsomra **Suvorexant**
Covered Uses	FDA approved indications
Required Medical Information	Documentation required to indicate that patient has tried and failed at least 3 hypnotics
Age Restriction	18 years of age or older
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Ambien CR **Zolpidem Controlled Release**
Covered Uses	FDA approved indications
Required Medical Information	Documentation required to indicate that patient has tried and failed at least two trials of hypnotics, including immediate-release Zolpidem
Age Restriction	18 years of age or older
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 12 months
Other Criteria	

MISCELLANEOUS AGENTS

Drug Names Brand Generic	 Deplin® L-MethylFolate **Non-Formulary**
FDA indication as Medical Food	For the distinct nutritional requirements of patients who have suboptimal L-Methyfolate levels in the cerebrospinal fluid, plasma, and/or red blood cells and have major depressive disorder with emphasis as adjunctive support for individuals who are on an antidepressant; for the distinct nutritional requirements of patients who have or are at risk for hyperhomocysteinemia and have schizophrenia who present with negative symptoms and/or cognitive impairment, with emphasis as an adjunctive support for individuals who have stabilized on antipsychotics
Required Medical Information for review	MDD: Homozygous for the T allele of the C677T polymorphism in the MTHFR gene Schizophrenia: Homozygous for the T allele of the C677T polymorphism in the MTHFR gene and Homocysteine level > 15 µmol/L
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Not a covered benefit with HSPM
Appeal	To be reviewed by BHRS and HPSM medical directors

Drug Names Brand Generic	 Sublocade® Buprenorphine Extended-Release Injection **Non-Formulary**
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Required Medical Information for review	• Treatment plan that includes counseling or psychosocial support • Stabilized on transmucosal buprenorphine for at least 7 days • No concurrent opioids or carisoprodol or supplemental bruprenorphine while on Sublocade • ONE of the following rationale for using injectable: o inability to take oral medications o nonadherence/noncompliance with oral medications o risk for diversion
Age Restriction	
Prescriber Restriction	DATA-waived physicians with unique DEA number
Other Restriction	300mg per 28 DS
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Provigil **Modafinil**
Covered Uses	FDA-approved indications; Off-label uses in ADHD, Major Depression
Required Medical Information	If ADHD: Patient tried and failed two trials of stimulants or formulary ADHD medications If Major Depression: Patient tried and failed 4 trials of antidepressants
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Vivitrol **Naltrexone Long-Acting Injectable**
Covered Uses	Alcohol use disorder or Alcohol dependence Opioid use disorder or Opioid dependence
Required Medical Information	1. Patient either: a. Has failed a trial of oral medication -such as Acamprosate, Disulfiram, Gabapentin or oral Naltrexone for alcohol dependence, -such as Buprenorphine, Methadone or oral Naltrexone for Opioid dependence Or b. Has unstable clinical status indicating that oral medication will not be taken consistently or a trial will likely fail
Age Restriction	18 years of age or older
Prescriber Restriction	
Other Restriction	380mg per 28 DS
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Names	Pimavanserin (Nuplazid®) **Non-Formulary**
FDA indication	Parkinson's Disease Psychosis
Required Medical Information for review	Documentation indicating treatment with Quetiapine has been ineffective, intolerable or contraindicated Consideration of Clozapine
Age Restriction	FDA approved for adults
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 12 months
Renewal requirement	Description of clinical improvement by Prescriber

Drug Name Brand Generic	 Topamax **Topiramate ER or Sprinkle**
Covered Uses	All medically accepted indications *Off label: alcohol dependence, anxiety disorders, eating disorder, impulse-control disorders, psychotropic-induced wt. gain, obesity *Other diagnosis: Patient must have tried and failed two formulary agents
Required Medical Information	Patient must have tried and failed formulary generic Topiramate formulations or have intolerance or contraindication to formulary generic Topiramate formulations
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	Ref: Essentials Clin Psychopharm,3rd ed

VMAT2 INHIBITORS

Drug Names	Deutetrabenazine (Austedo®) Valbenazine (Ingrezza®) **Non-Formulary**
FDA indication	Tardive Dyskinesia
Required Medical Information for review	2 baseline AIMS, rated at least 6 months apart • greater or equal to 3 in at least one subcategory AND overall severity category • patient's awareness of abnormal movements Renal function test within 6 months LFTs within 6 months (see Quantity Limit) QT status Consideration of • Amantadine, Clozapine, and Benzodiazepines • Refer to UptoDate review for TD Assessment of suicidality or violent behaviors Full list of concurrent medications to assess drug interactions (see Quantity Limit)
Age Restriction	FDA approved for adults - 18 years of age or older
Prescriber Restriction	Psychiatrists
Other Restriction	Hepatic/renal function and drug interactions will be assessed to determine if quantity limit will be warranted
Coverage Duration	One month trial initial request, 12 months for renewal
Renewal requirement	Repeat AIMS showing reduction in • at least one subcategory AND overall severity category • patient's awareness of abnormal movements Description of clinical improvement by prescriber

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