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NYRx the Medicaid Pharmacy Program

CNS Stimulants Prior Authorization Worksheet

Fax this form to 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete.

ENROLLEE INFORMATION

Enrollee Last Name: _____

Enrollee First Name: _____

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): _____

Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

National Provider Identifier (NPI) Number: _____

Board Certified Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone: _____ Prescriber Fax: _____

REQUESTED DRUG INFORMATION

Drug Name: _____

Drug Strength: _____

Quantity: _____ Number of Refills: _____

Directions: _____

Is this a New Prescription?

☐ Yes ☐ No

If **No**, date therapy was initiated: _____

Enrollee's Name (Last, First): _____

CLINICAL CRITERIA

1. What is the patient's diagnosis? _____

   ICD-10 diagnosis code: _____

2. Is the diagnosis an off-label use for this medication?

   ☐ Yes ☐ No

   If **Yes**, what is the clinical reason for off-label use?

   _____

Nuvigil (armodafinil) and Provigil (modafinil):

3. Is the patient being treated for excessive sleepiness associated with shift work sleep disorder or as an adjunct to standard treatment for obstructive sleep apnea?

   ☐ Yes ☐ No

Sunosi (solriamfetol):

4. Is the patient being treated for excessive daytime sleepiness associated with narcolepsy or obstructive sleep apnea?

   ☐ Yes ☐ No

Wakix (pitolisant):

5. Is the patient being treated for excessive daytime sleepiness (EDS) or cataplexy in adult patients with narcolepsy?

   ☐ Yes ☐ No

For PDL questions (non-preferred medications):

6. Are you requesting a non-preferred agent?

   ☐ Yes ☐ No

   If **Yes**, what is the clinical reason for not using a preferred agent?

   _____

7. Has the patient experienced treatment failure with a preferred CNS Stimulant?

   ☐ Yes ☐ No

8. Has the patient experienced an adverse drug reaction with a preferred CNS Stimulant?

   ☐ Yes ☐ No

9. Is there a documented history of successful therapeutic control with a non-preferred CNS Stimulant and transition to a preferred CNS Stimulant is medically contraindicated?

   ☐ Yes ☐ No

Enrollee's Name (Last, First): _____

DUR EDITS

DUR – Concurrent use of CNS Stimulant with Atypical Antipsychotic for patients < 18 years of age

10. Are you requesting concurrent use of a CNS Stimulant with an Atypical Antipsychotic (AAP)?
    ☐ Yes ☐ No

    If **Yes**, what is the name of the atypical antipsychotic: _____

11. Which diagnosis requires the use of an atypical antipsychotic with the CNS stimulant?

    _____

DUR – Therapeutic Duplication (TD); CNS Stimulant with a Benzodiazepine for all patients

12. Are you requesting concurrent use of a CNS Stimulant with a benzodiazepine (BZD)?
    ☐ Yes ☐ No

    Name of benzodiazepine: _____

13. What diagnosis is the benzodiazepine being prescribed for?

    _____

14. What is the clinical reason for concurrent use of a benzodiazepine with the CNS stimulant?

    _____

15. Are you aware that these 2 agents have opposing mechanisms of actions in the central nervous system which may cause rebound effects and tolerance leading to the use of higher doses and increased risk for fatal overdoses and are you monitoring for these adverse events?
    ☐ Yes ☐ No

DUR – Therapeutic Duplication (TD); CNS Stimulant and Opioid or Buprenorphine for Opioid Dependence for all patients

16. Are you requesting concurrent use of a CNS Stimulant with an opioid or a buprenorphine product for opioid dependence?
    ☐ Yes ☐ No

    Name of the opioid or buprenorphine product: _____

17. What diagnosis is the opioid or buprenorphine being prescribed for?

    _____

Enrollee's Name (Last, First): _____

DUR EDITS (CONTINUED)

18. What is the clinical reason for the concurrent use of either an opioid or a buprenorphine product for opioid dependence with a CNS Stimulant?

    _____

19. Are you aware that the concurrent use of these agents may lead to synergistic effects which may cause euphoric effects and increased risk for dependence, adverse events, (e.g., serotonin syndrome, overdose) and death and are you monitoring for these adverse events?

    ☐ Yes ☐ No

F/Q/D Limits and Dose Optimization Edit (see PDL for limits)

20. For requests that exceed the dose optimization limits, are you willing to change the strength?

    ☐ Yes ☐ No

    If **No**, what is the clinical reason for not using a higher available strength or exceeding the daily dose limit?

    _____

21. Are you requesting to exceed the FDA-approved/Compendia supported frequency, quantity, or duration limits?

    ☐ Yes ☐ No

    If **Yes**, what is the clinical reason for exceeding the FDA-approved/Compendia supported limits?

    _____

_____

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Fax Number: 1-800-268-2990

Billing Questions: 1-800-343-9000

For clinical concerns or Preferred Drug Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.