Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Medications

**Effective: 7/15/15**

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**OVERVIEW**

**FDA-APPROVED INDICATIONS**

**Adderall XR®**

Adderall XR is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

The efficacy of Adderall XR in the treatment of ADHD was established on the basis of two controlled trials in children aged 6 to 12, one controlled trial in adolescents aged 13 to 17, and one controlled trial in adults who met DSM-IV criteria for ADHD.

**Concerta®**

Concerta is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children 6 years of age and older, adolescents, and adults up to the age of 65.

**Daytrana®**

Daytrana is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

The efficacy of Daytrana in patients diagnosed with ADHD was established in two 7-week controlled clinical trials in children aged 6 to 12 and one 7-week, controlled clinical trial in adolescents aged 13 to 17.

**Focalin XR®**

Focalin XR is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients aged 6 years and older.

The effectiveness of Focalin XR in the treatment of ADHD in patients aged 6 years and older was established in two placebo-controlled studies in patients meeting DSM-IV criteria for ADHD.

**Metadate CD®**

Metadate CD is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

The efficacy of Metadate CD in the treatment of ADHD was established in one controlled trial of children aged 6 to 15 who met DSM-IV criteria for ADHD.

**Procentra®**

Procentra is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients aged 3 to 16.

**Quillivant XR™**

Quillivant XR is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

The efficacy of QUILLIVANT XR was established in a 2-week, placebo-controlled, laboratory classroom, crossover study in children aged 6-12 years with a diagnosis of ADHD. Patients in the trial met DSM-IV-TR® criteria for ADHD. Accumulated efficacy data from other methylphenidate products were also considered.

**Ritalin® and Ritalin SR®**

Ritalin® and Ritalin SR® are indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients aged 6 years and older

**Ritalin LA®**

Ritalin LA is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

The efficacy of Ritalin LA in the treatment of ADHD was established in one controlled trial of children aged 6 to 12 who met DSM-IV criteria for ADHD
**Vyvanse®**

Vyvanse is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) and for moderate to severe binge eating disorder in adults.

The efficacy of Vyvanse was established in three short-term trials in children aged 6 to 12, one short-term trial in children aged 13 to 17 and two short-term and one maintenance trial in adults.

Effective 7/15/15, CNS stimulant medications indicated for ADHD require prior authorization for members 25 years of age and older.

### PHARMACY COVERAGE GUIDELINES

Tufts Health Plan – Network Health may authorize coverage of a stimulant ADHD medication for members 25 years of age and older when all of the following criteria are met and limitations do not apply:

- **Diagnosis of one of the following:**
  - ADHD
  - Narcolepsy
  - Depressive condition in which the stimulant will be used as an augmenting agent with concomitant antidepressant medication(s) and bipolar disease, thyroid disease, cardiovascular conditions have been ruled out
  - Traumatic Brain Injury

- **Provider attestation that they have reviewed member-specific medication usage through state Online Prescription Monitoring Program(s) within the past year**

- **If the request is for an immediate-release (IR) formulation,**
  - The provider indicates there is no concern with active substance abuse or diversion, and
  - The provider indicates clinical rationale of therapy with an IR formulation instead of long-acting/extended-release formulations

### LIMITATIONS

- Requests for quantities that exceed the quantity limit will be reviewed according to the Quantity Limit criteria.
- Requests for brand-name products, with AB-rated generics, will be reviewed according to Brand Name criteria.

### CODES

None

### REFERENCES

6. Daytrana [methylphenidate transdermal] [prescribing information]. Miami, FL: Noven: October 2013
8. Transdermal Methylphenidate (Daytrana) for ADHD. The Medical Letter June 2006; Vol 48: 1237.

### APPROVAL HISTORY

- 04/14/15: Reviewed by the Pharmacy and Therapeutics Committee; consolidated individual criteria; established criteria for members 25 years of age and older

### BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION

Pharmacy Medication Request Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions
are made. They are used in conjunction with the applicable *Member Handbook* and in coordination with the member’s physician(s). Pharmacy Medication Request Guidelines are developed for selected therapeutic classes or drugs found to be safe but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medication Request Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medication Request Guidelines apply to fully insured *Tufts Health Direct* offerings unless otherwise noted in this policy or the applicable *Member Handbook*. Check the *Preferred Drug List* (formulary) in the pharmacy section of our website to determine if the drug requires you to get prior authorization.

For *Tufts Health Together* (MassHealth), please refer to the *Tufts Health Together Pharmacy Medical Necessity Guidelines*. For *Tufts Health Unify* (Medicare-Medicaid One Care for people ages 21 – 64), please refer to the *Tufts Health Unify Prior Authorization Medical Necessity Guidelines*.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines, when applicable, and adherence to plan policies and procedures and claims editing logic.