BEHAVIORAL HEALTH & RECOVERY SERVICES

SAN MATEO COUNTY

PRIOR AUTHORIZATION PROCEDURES

12/8/2017

Table of Contents

ANXIOLYTICS 4

BENZODIAZEPINES GUIDELINES 6

ANTIDEPRESSANTS 7

ANTIPARKINSON AGENTS 9

ANTIPSYCHOTICS, ATYPICALS—CONCURRENT USE 11

ANTIPSYCHOTICS 12

ADHD MEDICATIONS 21

HYPNOTICS 29

MISCELLANEOUS AGENTS 30

VMAT2 INHIBITORS 35

INDEX 36

BEHAVIORAL HEALTH & RECOVERY SERVICES

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.

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	
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	
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	
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	
Required Medical Information	Patient unable to take oral form of this medication
Age Restriction	
Prescriber 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	
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	
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	
Coverage Duration	Approved all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Brintellix **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	
Coverage Duration	Approved 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	
Coverage Duration	Approved for up to 3 months
Other Criteria	

Drug Name Brand Generic	 Parlodel **Bromocriptine**
Covered Uses	All medically accepted indications
Age Restriction	
Prescriber Restriction	
Coverage Duration	Approved 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	Approved for up to 3 months
Prescriber Restriction	
Coverage Duration	
Other Criteria	

ANTIPSYCHOTICS, ATYPICALS—CONCURRENT USE

Generic	Brand	Exception/Other
ARIPIPRAZOLE	ABILIFY	QL, PA for discmelt and IM
ARIPIPRAZOLE	ABILIFY MAINTENA	PA
LAUROXIL	ARISTADA	PA
ASENAPINE	SAPHRIS	PA
BREXIPIPRAZOLE	REXULTI	PA
CARIPRAZINE	VRAYLAR	PA
CLOZAPINE	CLOZARIL	PA for brand, liquid
CLOZAPINE	FAZACLO	PA
ILOPERIDONE	FANAPT	PA
LURASIDONE	LATUDA	QL
OLANZAPINE	ZYPREXA	QL, PA for brand, Zydis, IM
OLANZAPINE	RELPREV	NF
PALIPERIDONE	INVEGA	PA
PALIPERIDONE	INVEGA SUSTENNA	PA
PALIPERIDONE	INVEGA TRINZA	PA
RISPERIDONE	RISPERDAL	PA for brand, M-tabs
RISPERIDONE	RISPERDAL CONSTA	PA
QUETIAPINE	SEROQUEL, XR	QL, PA for brand
ZIPRASIDONE	GEODON	PA for brand, IM

Covered Uses	All medically accepted indications
Required Medical Information	When two atypical antipsychotics are used concurrently, including during cross titration, Brief Psychiatric Rating Scale (BPRS) must accompany PAR form, whether initial or renewal. If one of the two antipsychotics has been DC'd or will be DC'd within 30days, then approve x 30 days without BPRS.
Age Restriction	
Prescriber Restriction	Psychiatrist
Coverage Duration	Initial--approved all strengths for 6 months Renewal—approved all strengths for 3 yrs if renewal criteria met
Other Criteria	Renewal criteria: BPRS summary scores 20% lower than baseline AND clinical improvement; or Medical Director approval

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 QL: #90/90DS for oral tabs and discmelt; May override QL during titration up to 3 mo BRAND: tried and failed generic, approve up to 12months Abilify Maintena or Aristada: see separate approval criteria
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for ODT, BRAND, oral soln, all strengths up to 12 months Approved for Injectable or QL up to 3 months
Other Criteria	Must meet Concurrent Use Criteria

Drug Name Brand Generic	 Abilify Maintena or Aristada **Aripiprazole Long-acting Injectable**
Covered Uses	All medical 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	#1 per 30DS
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	Must meet Concurrent Use 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	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	Must meet Concurrent Use Criteria

Drug Name Brand Generic	 Rexulti **Brexipiprazole**
Covered Uses	All medical accepted indications
Required Medical Information	Schizophrenia: tried and failed two generic atypical antipsychotics Major depression: tried and failed one generic atypical antipsychotics, used in adjunct with antidepressant
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	Must meet Concurrent Use Criteria

Drug Name Brand Generic	 Vraylar **Cariprazine**
Covered Uses	All medically accepted indications
Required Medical Information	Tried and failed two generic atypical antipsychotics
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	Must meet Concurrent Use Criteria

Drug Name Brand Generic	 Fazaclo or Versacloz **Clozapine sublingual 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 up to 12 months
Other Criteria	Must meet Concurrent Use 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	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	Must meet Concurrent Use 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 QL: #90/90 for all strengths except 7.5mg May override QL during titration for 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	
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	Must meet Concurrent Use Criteria

Drug Name Brand Generic	 Invega oral **Paliperidone**
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: see separate approval criteria
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	Must meet Concurrent Use Criteria

Drug Name Brand Generic	 Invega Sustenna **Paliperidone 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	#1 per 30DS
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	

Drug Name Brand Generic	 Invega Trinza **Paliperidone Long-Acting Injectable**
Covered Uses	All medically accepted 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	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	Must meet Concurrent Use Criteria

Drug Name Brand Generic	 Seroquel **Quetiapine**
Covered Uses	All medically accepted indications
Required Medical Information	QL on Seroquel XR 50mg, 150mg, 200mg #90/ 90DS Brand Quetiapine: tried and failed generic
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for QL, all strengths Brand, up to 12 months
Other Criteria	Must meet Concurrent Use 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 up to 12 months
Other Criteria	Must meet Concurrent Use Criteria

Drug Name Brand Generic	 Risperdal Consta **Risperdione 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	#1 per 14DS
Coverage Duration	Approved for all strengths 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 up to 3 months
Other Criteria	Must meet Concurrent Use 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
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

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 yrs and older
Prescriber Restriction	none
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 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

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
Coverage Duration	Variable depending on criteria below
Other Criteria	1. Treatment initiation phase: approve <u>90 days</u> 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 <u>different</u> classes of stimulants (eg. amphetamine and methylphenidate class 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve <u>30 days</u> 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 <u>12 month</u> ONLY if dosing and frequency within FDA range, and meet Criteria #2 above

Drug Name Brand Generic	 Desoxyn **Methamphetamine**
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
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

Drug Name	

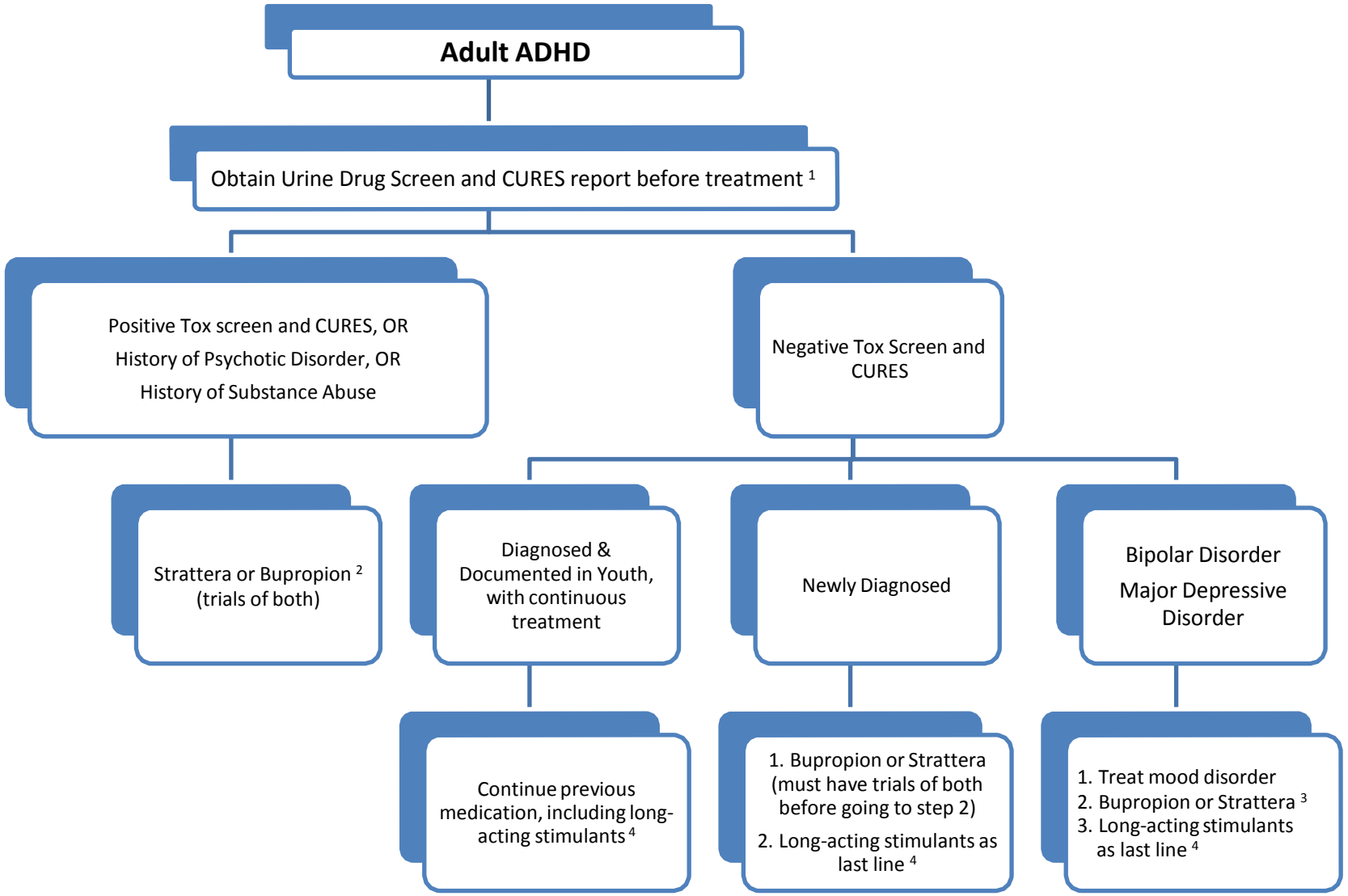
Brand Generic	Ritalin **Methylphenidate IR**
Covered Uses	FDA approved indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 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
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

Drug Name	

Brand Generic	Cylert **Pemoline**
Covered Uses	All medically accepted indications
Required Medical Information	Patient has a normal baseline ALT (7-56u/l) that indicates normal liver function. Patient will have liver function test monitoring every (2) two weeks
Age Restriction	
Prescriber Restriction	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	

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 yrs of age or older
Prescriber Restriction	
Coverage Duration	Approved 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 yrs of age or older
Prescriber Restriction	
Coverage Duration	Approved for up to 12 months
Other Criteria	

MISCELLANEOUS AGENTS

Nonformulary, PA submission requirements:

Drug Names	L-MethylFolate (Deplin®)
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	
Prescriber	
Coverage Duration	Not a covered benefit with HSPM
Quantity Limit	
Appeal	To be reviewed by BHRS and HPSM medical directors

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	
Coverage Duration	Approved for all strengths 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 Opiod Dependence OR b. Has unstable clinical status indicating that oral medication will not be taken consistently or a trial will likely fail. The patient is also informed of, referred to, or enrolled in a treatment program or community support program, such as Alcoholic Anonymous or Narcotics Anonymous
Age Restriction	18 yrs of age or older
Prescriber Restriction	
Coverage Duration	Approved for 380mg #1/30DS up to 12 months
Other Criteria	

Nonformulary, PA submission requirements:

Drug Names	Pimavanserin (Nuplazid®)
FDA indication	Parkinson's Disease Psychosis
Required Medical Information for review	Trial of Quetiapine Consideration of Clozapine
Age	FDA approved for adults
Prescriber	
Coverage Duration	6 months
Quantity Limit	
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	

Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	Ref: Essentials Clin Psychopharm,3rd ed

Drug Name Brand Generic	 Chantix **Varenicline**
Covered Uses	Smoking cessation
Required Medical Information	Documentation required to indicate patient is currently enrolled in a smoking cessation program or have a plan of ongoing counseling. Other documentation required includes trial and failure of nicotine patches or oral bupropion.
Age Restriction	
Prescriber Restriction	
Coverage Duration	Approved for all strengths up to 12 weeks
Other Criteria	Renewal request may be approved for a second 12-week period

VMAT2 INHIBITORS

Nonformulary, PA submission requirements:

Drug Names	Deutetrabenazine (Austedo®) Valbenazine (Ingrezza®)
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 Clozapine Assessment of suicidality or violent behaviors Full list of concurrent medications to assess drug interactions (see Quantity Limit)
Age	FDA approved for adults
Prescriber	psychiatrists
Coverage Duration	One month trial
Quantity Limit	Hepatic/renal function and drug interactions will be assessed to determine if quantity limit will be warranted
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

INDEX

A

Abilify 11, 12
Abilify Maintena 13
Adderall 21
Adult ADHD Treatment Guidelines 27
Alprazolam 4
Ambien 29
Amphetamine 21
Aripiprazole 11, 12
Aripiprazole Long-acting Injectable 13
Aristada 11
Ativan 5
Austedo 35

B

Belsomra 29
Benadryl 10
Benztropine 9
Brexipiprazole 11, 14
Brintellix 8
Bromocriptine 9

C

Cariprazine 14
Chantix 34
Clozapine 11
Clozapine sublingual or oral solution 15
Clozaril 11
Cogentin 9
Cylert 26

D

Deplin 30
Deutetrabenazine (Austedo®) 35
Diphenhydramine 10

E

Emsam 7

F

Fanapt 15
Fazaclo 15

G

Geodon 11, 20

I

Iloperidone 15
Ingrezza 35
Invega 17
Invega Sustenna 17
Invega Trinza 11, 18

L

Lauroxil 11
L-MethylFolate 30

M

Modafinil 31

N

Naltrexone Long-acting Injectable 32
Nuplazid 33

O

Olanzapine 11
Olanzapine Injectable, ODT,Oral solution 16

P

Paliperidone 11, 17
Paliperidone Long-acting Injectable 17
Parlodel 9
Paroxetine 7
Paxil 7
Pemoline 26
Pimavanserin 33
Provigil 31

Q

Quetiapine 11, 18

R

Rexulti 11, 14
Risperdal 11
Risperdal Consta 19
Risperdal M-tab 19
Risperdione Long-acting Injectable 19
Risperidone 11
Risperidone ODT 19

S

Selegiline 7
Seroquel 11, 18

Stimulant Maximum Dose 28
Suvorexant 29

T

Topamax 33
Topiramate 33

V

Valbenazine (Ingrezza®) 35
Varenicline 34
Viibryd 8
Vilozodone 8
Vivitrol 32
Vortioxetine 8
Vraylar 14

X

Xanax 4

Z

Ziprasidone 11, 20
Zolpidem 29
Zyprexa 11
Zyprexa IM 11
Zyprexa Injectable, Oral solution, Zydis 16