PRIOR AUTHORIZATION POLICY – THERAPEUTIC GUIDELINE

SUBJECT: Attention Disorders

DATE ESTABLISHED: 09/28/2009

DESCRIPTION

This therapeutic guideline policy addresses the use of the following agents for the treatment of attention disorders: **stimulants** (e.g., methylphenidate, dexmethylphenidate, lisdexamfetamine dimesylate), **amphetamines** (e.g., mixed amphetamine salts, dextroamphetamine), and **atomoxetine**. The goals of this policy are to promote overall disease management such that medication treatment is supported by adjunctive psychosocial programs, ample patient contact, and frequent follow-up visits throughout the course of therapy to address non-medication treatment alternatives, comorbid disorders, dosage titration, adverse effects, and drug diversion and misuse.

DIAGNOSIS

Attention-Deficit Hyperactivity Disorder is diagnosed based on the criteria presented in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). However, psychiatric conditions can be diagnosed in patients as young as 2 years old using developmentally sensitive criteria such as the Research Diagnostic Criteria: Preschool Age (AACAP Task Force on Research Diagnostic Criteria: Infancy Preschool Age, 2003) and the Diagnostic Criteria: 0Y3R (Zero to Three Diagnostic Classification Task Force, 2005).

TREATMENT OPTIONS

The American Academy of Child and Adolescent Psychiatry (AACAP) guidelines for treatment of Attention Deficit-Hyperactivity Disorder recommend initial parent training and a structured preschool setting that may progress to low dose medication with frequent monitoring. Behavior modification therapy may be useful if implemented consistently. The AACAP suggests medication use only in the most severe cases, or where parent training/school placement are unavailable or unsuccessful. If medications are used, the AACAP suggests daily treatment without weekend holidays. The American Academy of Pediatrics (AAP) recommendations, while not specific to preschoolers, follows the same general lines as the AACAP. Re-evaluation (in the case of treatment failure) and ongoing assessment (if treatment success) are recommended. The National Institute of Mental Health's ongoing Preschool ADHD Treatment Study (PATS) provided clinical guidance for children with ADHD 3—5 years of age. PATS showed preschoolers with severe ADHD symptoms can benefit from medication, but doctors should weigh that benefit against the potential for these very young children to be more sensitive than older children to the medication's side effects, and monitor use closely.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage for one year of **stimulants** (e.g., methylphenidate, dexmethylphenidate), **amphetamines** (e.g., mixed amphetamine salts, dextroamphetamine, lisdexamfetamine dimesylate), and **atomoxetine** is recommended for those who meet the following criteria:

1. **WV CHIP members-**
    a. The requested product must be a generic or a preferred brand on the WV CHIP formulary. If the product requested is **not on the WV CHIP formulary**, the requested product **will not be covered even if the following criteria are met**.

2. **Attention Disorder-**

    a. **Diagnosis of an Attention Disorder** [Attention-Deficit/Hyperactivity Disorder (ADHD) or Attention-Deficit Disorder (ADD)] must be confirmed and documented by a physician. For example, diagnosis for attention disorders may be confirmed by using DSM-IV, Research Diagnostic Criteria: Preschool Age (AACAP Task Force on Research Diagnostic Criteria: Infancy Preschool Age, 2003) or the Diagnostic Criteria: 0Y3R (Zero to Three Diagnostic Classification Task Force, 2005).

    b. **Behavior therapy** (nondrug therapy) must be tried before pharmacotherapy in patients new to drug therapy. A detailed, written plan for behavior therapy management must be initiated by an appropriately licensed & credentialed professional [physician, psychiatrist, psychologist, social worker trained and experienced with Attention Disorders, or an ADHD Coach Certified by the Institute for the Advancement of AD/HD Coaching (IAAC) . If patient is not new to drug therapy, behavior therapy should be used as an adjunct to drug therapy. Some examples of behavior therapy include: positive reinforcement, response cost, time out, and token economy.

    c. **The patient must be evaluated in person by a physician** initially and on an annual basis to assess the need for drug therapy, and monitor non-medication treatment alternatives, co-morbid disorders, dosage titration, adverse effects, and drug diversion and misuse.

    d. **The patient's age must be within the FDA-approved age range** for the medication being prescribed. The FDA-approved age range applies to the brand and generic version of the drug.

BRAND NAME	GENERIC NAME	FDA-APPROVED AGE RANGE FOR ADD/ADHD
Adderall	Immediate-Release Amphetamine-Dextroamphetamine	Ages 3 years and older
Adderall XR	Extended-Release Amphetamine-Dextroamphetamine	Ages 6 years and older
Concerta, Ritalin, Metadate, Methylin	Immediate- Release and Extended-Release Methylphenidate HCl	Ages 6 years and older; for Concerta up to ≤65 years old
Daytrana	Methylphenidate TD	Ages 6 to 12 years
Desoxyn	Methamphetamine HCl	Ages 6 to 18 years
Dexedrine	Immediate-Release Dextroamphetamine Sulfate	Ages 3 to 16 years
Dexedrine Spansule	Extended-Release Dextroamphetamine Sulfate	Ages 6 to 16 years
Focalin	Immediate-Release Dexmethylphenidate	Ages 6 years and older
Focalin XR	Extended-Release Dexmethylphenidate	Ages 6 to 18 years

Strattera	Atomoxetine	Ages 6 years and older
Vyvanse	Lisdexamfetamine Dimesylate	Ages 6 years and older

3. Narcolepsy-

a. Dextroamphetamine sulfate (Dexedrine) brand or generic, immediate-release amphetamine-dextroampetamine (Adderall) brand or generic, immediate release methylphenidate (Ritalin) brand or generic, or sustained-release methylphenidate (Ritalin SR) brand or generic will be covered for narcolepsy in patients ages 6 and older.

4. **Nuvigil/Provigil-**
   a. See Nuvigil/Provigil policy.

EXCLUSIONS

Coverage of stimulants, amphetamines, and atomoxetine are not recommended in the following circumstances:

1. Coverage is not recommended for circumstances *not* listed in the Recommended Authorization Criteria.