Louisiana Medicaid
Stimulants and Related Agents

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- Clinical authorization for **all** preferred and non-preferred agents for recipients younger than 7 years of age; **OR**
- Prior authorization for non-preferred agents for recipients 7 years of age and older.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation and Continuation of Therapy for ALL Stimulants and Related Agents (both preferred and non-preferred) for Children under 7 years of Age [except armodafinil (Nuvigil®), modafinil (Provigil®), pitolisant (Wakix®) or solriamfetol (Sunosi®)]

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
    - The child has had *treatment failure* with at least one preferred product; **OR**
    - The child has had an *intolerable side effect* to at least one preferred product; **OR**
    - The child has *documented contraindication(s)* to all of the preferred products that are appropriate for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- The child has a diagnosis approved for the medication requested (see POS Edits); **AND**
- **ONE** of the following (due to this diagnosis) is true and is **stated on the request**:
    - Child has had a trial of behavioral therapy and has ongoing impairing and/or dangerous symptoms; **OR**
    - Child has started behavioral therapy but has extremely impairing and/or potentially dangerous symptoms; **OR**
    - Child has been referred to behavioral treatment but has extremely impairing and/or potentially dangerous symptoms that warrant treatment before therapy has had a chance to have an effect (with plan to follow up); **OR**
    - There are no known behavioral therapy resources available to this child, who has extremely impairing and/or potentially dangerous symptoms; **OR**
    - **ALL** of the following:
        - The child is 6 years of age; **AND**
        - The diagnosis for the requested medication is attention deficit hyperactivity disorder (ADHD); **AND**
        - By submitting this request, the provider attests that behavioral treatment has been prescribed in addition to the requested medication**;**

OR

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- The child has a diagnosis approved for the medication requested (see POS Edits); **AND**

- The prescriber **states on the request** that the recipient is established on the requested medication with positive clinical outcomes**.**

Duration of approval for initiation and continuation of therapy for ALL Stimulants and Related Agents (both preferred and non-preferred) for Children under 7 years of Age [except armodafinil (Nuvigil®), modafinil (Provigil®), pitolisant (Wakix®) or solriamfetol (Sunosi®)]: 12 months or up to the recipient's 7th birthday, whichever is less

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Approval Criteria for Initiation of Therapy for Non-Preferred Stimulants and Related Agents [except armodafinil (Nuvigil®), modafinil (Provigil®), pitolisant (Wakix®) or solriamfetol (Sunosi®)] for Recipients 7 years of Age and Older

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
    - The recipient has had *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated**; AND**
- The recipient has a diagnosis approved for the medication requested (see POS Edits)**.**

Approval Criteria for Continuation of Therapy for Non-Preferred Stimulants and Related Agents [except armodafinil (Nuvigil®), modafinil (Provigil®), pitolisant (Wakix®) or solriamfetol (Sunosi®)] for Recipients 7 Years of Age and Older

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy for Non-Preferred Stimulants and Related Agents [except armodafinil (Nuvigil®), modafinil (Provigil®), pitolisant (Wakix®) or solriamfetol (Sunosi®)] for Recipients 7 Years of Age and Older: 12 months

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Approval Criteria for Initiation of Therapy for Non-Preferred Armodafinil (Nuvigil®), Modafinil (Provigil®), Pitolisant (Wakix®) and Solriamfetol (Sunosi®)

- ~~On the date of the request, the recipient age is:~~
    - ~~17 years of age or older for armodafinil or modafinil; **OR**~~
    - ~~18 years of age or older for pitolisant or solriamfetol; **AND**~~
- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
    - The recipient has had *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate for the condition being treated; **OR**

    - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- The recipient has a diagnosis approved for the medication requested (see POS Edits).

Approval Criteria for Continuation of Therapy for Non-Preferred Armodafinil (Nuvigil®), Modafinil (Provigil®), Pitolisant (Wakix®) and Solriamfetol (Sunosi®)

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy for Non-Preferred Armodafinil (Nuvigil®), Modafinil (Provigil®), Pitolisant (Wakix®) and Solriamfetol (Sunosi®): 3 months

References

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; Retrieved from https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; Retrieved from https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Gleason, M., Egger, H., Emslie, G., Greenhill, L., Kowatch, R., Lieberman, A., Luby, J., Owens, J., Scahill, L., Scheeringa, M., Stafford, B., Wise, B. and Zeanah, C. (2007). Psychopharmacological Treatment for Very Young Children: Contexts and Guidelines. Journal of the American Academy of Child & Adolescent Psychiatry, 46(12), pp.1532-1572.

Revision / Date	**Implementation Date**
Single PDL Implemented	May 2019
Added specific wording for use of Focalin XR® and ProCentra® / November 2019	January 2020
Removed POS information, added Wakix®, formatting changes, updated references / July 2020	July 2020
Modified to apply new age requirement for behavioral health clinical authorization, updated references / September 2020	January 2021
Removed preferred wording for ProCentra®, formatting changes, updated references / November 2020	January 2021
Added wording for Sunosi®, formatting changes / September 2021	October 2021
Added specific wording for use of Adderall XR®, removed specific wording for use of Focalin XR® / October 2021	January 2022
Removed specific wording for the use of Adderall XR®, formatting changes / April 2024	July 2024
Removed age limit wording for Nuvigil®, Provigil®, Wakix® and Sunosi® / August 2024	January 2025