Clinical Policy: MHS Stimulants

Reference Number: IN.CP.PMN.274
Effective Date: 01.01.20
Last Review Date: 04.23 Revision Log

Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The intent of the criteria is to limit utilization of Stimulates for members 19 and older to only those with a proper Behavior Health Diagnosis. Duplicate stimulant therapy is characterized as claims for two different stimulant drug salts, distinguished by differentiated ten-digit GPIs. Duplicate extended release stimulant therapy of both equivalent and distinct drug salts will be reviewed for medical necessity.

FDA Approved Indication(s)

Extended and intermediate release methylphenidate and amphetamine products are indicated for attention-deficit/hyperactivity disorder (ADHD

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® Immediate release and extended release stimulates are medically **necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Behavior Health Criteria (must meet all)**:**

1. Behavior Health Diagnosis: See appendix A;
2. Age ≥ 19 years and older;
3. Request is for formulary amphetamine product or formulary methylphenidate at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced to all relevant formulary amphetamine and methylphenidate products
4. If request is for concurrent use, then request must be for an ER product with an IR product of the same chemical entity without PA (IE: Vyvanse with either Adderall IR or dextroamphetamine).
5. Duplicate extended release stimulant therapy of both equivalent and distinct drug salts will be reviewed for medical necessity.
   The medications involved in the therapeutic duplication are being cross tapered or discontinued (approval granted for 45 days)

Approval duration: Length of Benefit

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Attention Deficit Hyperactivity Disorder (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;

Approval duration: Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

IV. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

V. Appendices/General Information

Appendix A: Diagnosis Codes

Appendix A:

Diagnosis Codes
Attention-deficit hyperactivity disorder, predominantly inattentive type
Attention-deficit hyperactivity disorder, predominantly hyperactive type
Attention-deficit hyperactivity disorder, unspecified type
Attention-deficit hyperactivity disorder, combined type
Attention-deficit hyperactivity disorder, other type
Attention-Deficit Hyperactivity Disorders
Narcolepsy
Binge Eating Disorder (Lisdexamfetamine only)
Depression
Mania (dextroamphetamine only)
Cocaine Dependence (Dextroamphetamine only)
Personality Disorder

Schizophrenia
Sleep Deprivation

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created	10/19	10/19
Updated to clarify ER and IR formulations are included in this edit. Also added language concerning Concurrent use.	06/20	
Updated Appendix A to match State Criteria	10/7/20	
Annual review: no changes		10/20
Updated the Policy description, specified that request is for formulary amphetamine, and added step 5	06/15/21	
Annual Review- No Changes	02/2023	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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