Overview
N/A

Coverage Guidelines
Authorization may be granted when the following criteria are met:
1. Member has a diagnosis of attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD) AND
2. Prescriber has provided documentation of an inadequate response, adverse reaction, or contraindication to Concerta® (methylphenidate extended-release) AND
3. Prescriber has provided documentation of an inadequate response, adverse reaction, or contraindication to Focalin XR® (dexamphetamine extended-release)

Please note: Additional criteria may apply for members under the age of 18. Please refer to the MassHealth Pediatric Behavioral Health Medication Initiative guideline for criteria.

Continuation of Therapy
Reauthorization requires physician documentation indicating a positive response to therapy.

Limitations
1. Approvals will be granted for 12 months
2. A quantity limit of 60 capsules per 30 days applies
   a. Concurrent therapy with long-acting agents will require PA for quantities > 60 units/month (all agents combined). Concurrent therapy with a short- or intermediate-acting agent and a long-acting agent will also require PA for quantities > 90 units/month (all agents combined). Individual drug quantity limits may also apply.
References
N/A

Review History
03/01/18 – Effective (adopted MH RS)
02/20/19 – Reviewed in P&T Meeting

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