**Central Nervous System (CNS) Agents: Narcolepsy**

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| Criteria 1 | NP- Sunosi, Wakix, Xyrem, Sodium Oxybate |
| Criteria 2 | NP- Xywav |
| Criteria 3\* | Amphetamine/Dextroamphetamine IR |
| Criteria 4 \* | Amphetamine/Dextroamphetamine ER |
| Criteria 5\* | Dextroamphetamine ER |
| Criteria 6 \* | Methylphenidate Tab, Methylphenidate ER |

\*Items have standalone criteria sets – in both ADHD and Narcolepsy classes

AR, QL for ADHD class

AR for narcolepsy class

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| **Criteria Title** | Central Nervous System (CNS) Agents: Narcolepsy | | |
| **Criteria Subtitle** | Sunosi, Wakix, Xyrem, Sodium Oxybate | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| SODIUM OXYBATE | 050813 | GCNSeqNo |
| SUNOSI | 079597 | GCNSeqNo |
| SUNOSI | 079598 | GCNSeqNo |
| WAKIX | 079457 | GCNSeqNo |
| WAKIX | 079458 | GCNSeqNo |
| XYREM | 050813 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs - either (1) modafinil or armodafinil; or (2) preferred methylphenidate or amphetamine drug?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 5 | 1002 |  | Select | Is the request for brand Xyrem or generic sodium oxybate? | Y | 1003 |
| N | 1005 |
| 6 | 1003 |  | Select | Which product is being requested? | Brand Xyrem | 1005 |
| Generic sodium oxybate | 1004 |
| 7 | 1004 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | 1005 |
| N | 1235 |
| 8 | 1005 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1006 |
| N | END (Pending Manual Review) |
| 9 | 1006 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 12 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Narcolepsy | | |
| **Criteria Subtitle** | Xywav | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| XYWAV | 081341 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the provider submitted documentation of the patient’s documented adherence to a sodium restricted diet? | Y | 1001 |
| N | 1235 |
| 4 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs - either (1) modafinil or armodafinil; or (2) preferred methylphenidate or amphetamine drug?  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1002 |
| 5 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1236 |
| 6 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | END (Pending Manual Review) |
| 7 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 10 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents, Narcolepsy | | |
| **Criteria Subtitle** | Amphetamine/Dextroamphetamine IR | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| AMPHETAMINE/DEXTROAMPHETAMINE IR | 004999 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE IR | 005000 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE IR | 005001 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE IR | 034359 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE IR | 047131 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE IR | 047132 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE IR | 047133 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0996 |  | Select | What is the patient’s diagnosis? | Narcolepsy | 0997 |
| ADHD | 0998 |
| Other | 1235 |
| 2 | 0997 |  | Select | Is the patient younger than 3 years old? | Y | 1235 |
| N | 1238 |
| 3 | 0998 |  | Select | Is the patient younger than 3 years old? | Y | 1235 |
| N | 0999 |
| 4 | 0999 |  | Select | Is Amphetamine-Dextroamphetamine Tab 30 MG being requested? | Y | 1001 |
| N | 1000 |
| 5 | 1000 |  | Select | Ohio Medicaid covers up to 102 tablets per 34 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 6 | 1001 |  | Select | Ohio Medicaid covers up to 68 tablets per 34 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 7 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 8 | 1237 |  | Free Text | Please provide the rationale for the dose and frequency being requested. | END (Pending Manual Review) | |
| 9 | 1238 |  | Free Text | A PA is not required for those 3 years of age and older. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents, Narcolepsy | | |
| **Criteria Subtitle** | Amphetamine/Dextroamphetamine ER | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | 048701 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | 048702 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | 048703 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | 050428 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | 050429 | GCNSeqNo |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | 050430 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0996 |  | Select | What is the patient’s diagnosis? | Narcolepsy | 0997 |
| ADHD | 0998 |
| Other | 1235 |
| 2 | 0997 |  | Select | Is the patient younger than 6 years old? | Y | 1235 |
| N | 1238 |
| 3 | 0998 |  | Select | Is the patient younger than 6 years old? | Y | 1235 |
| N | 0999 |
| 4 | 0999 |  | Select | Ohio Medicaid covers up to 34 capsules per 34 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 5 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 6 | 1237 |  | Free Text | Please provide the rationale for the dose and frequency being requested. | END (Pending Manual Review) | |
| 7 | 1238 |  | Free Text | A PA is not required for those 6 years of age and older. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents, Narcolepsy | | |
| **Criteria Subtitle** | Dextroamphetamine ER | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| DEXTROAMPHETAMINE ER | 005005 | GCNSeqNo |
| DEXTROAMPHETAMINE ER | 005006 | GCNSeqNo |
| DEXTROAMPHETAMINE ER | 005007 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0996 |  | Select | What is the patient’s diagnosis? | Narcolepsy | 0997 |
| ADHD | 0998 |
| Other | 1235 |
| 2 | 0997 |  | Select | Is the patient younger than 6 years old? | Y | 1235 |
| N | 1238 |
| 3 | 0998 |  | Select | Is the patient younger than 6 years old? | Y | 1235 |
| N | 0999 |
| 4 | 0999 |  | Select | Is Dextroamphetamine Sulfate ER Cap 15 MG being requested? | Y | 1001 |
| N | 1000 |
| 5 | 1000 |  | Select | Ohio Medicaid covers up to 34 capsules per 34 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 6 | 1001 |  | Select | Ohio Medicaid covers up to 136 capsules per 34 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 7 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 8 | 1237 |  | Free Text | Please provide the rationale for the dose and frequency being requested. | END (Pending Manual Review) | |
| 9 | 1238 |  | Free Text | A PA is not required for those 6 years of age and older. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents, Narcolepsy | | |
| **Criteria Subtitle** | Methylphenidate Tab, Methylphenidate ER | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 004029 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 044072 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 053056 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 053057 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 053058 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 053059 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 053060 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 053061 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 053974 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 060545 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 060546 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 060547 | GCNSeqNo |
| METHYLPHENIDATE ER CAP (gen of Metadate CD, Ritalin LA) | 072092 | GCNSeqNo |
| METHYLPHENIDATE ER TAB (gen of Concerta, Methylin ER, Ritalin SR) | 045981 | GCNSeqNo |
| METHYLPHENIDATE ER TAB (gen of Concerta, Methylin ER, Ritalin SR) | 045982 | GCNSeqNo |
| METHYLPHENIDATE ER TAB (gen of Concerta, Methylin ER, Ritalin SR) | 047318 | GCNSeqNo |
| METHYLPHENIDATE ER TAB (gen of Concerta, Methylin ER, Ritalin SR) | 050172 | GCNSeqNo |
| METHLYPHENIDATE TAB | 004026 | GCNSeqNo |
| METHLYPHENIDATE TAB | 004027 | GCNSeqNo |
| METHLYPHENIDATE TAB | 004028 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 2002 |  | Select | What is the patient’s diagnosis? | Narcolepsy | 2003 |
| ADHD | 2004 |
| Other | 1235 |
| 2 | 2003 |  | Select | Is the patient younger than 6 years old? | Y | 1235 |
| N | 1238 |
| 3 | 2004 |  | Select | Is the patient younger than 6 years old? | Y | 1235 |
| N | 2005 |
| 4 | 2005 |  | Select | Which product is being requested? | Methylphenidate HCl Tab (all strengths) | 2006 |
| Methylphenidate HCl CR Cap (generic Metadate- all strengths) | 2007 |
| Methylphenidate HCl CR Tab (all strengths excluding 10 MG & 20 MG) | 2008 |
| Methylphenidate HCl CR Tab 10 MG & 20 MG | 2009 |
| Other | END (Pending Manual Review) |
| 5 | 2006 |  | Select | Ohio Medicaid covers up to 102 tablets per 34 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 6 | 2007 |  | Select | Ohio Medicaid covers up to 34 capsules per 34 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 7 | 2008 |  | Select | Ohio Medicaid covers up to 34 tablets per 34 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 8 | 2009 |  | Select | Ohio Medicaid covers up to 102 tablets per 34 days. Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 9 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 10 | 1237 |  | Free Text | Please provide the rationale for the dose and frequency being requested. | END (Pending Manual Review) | |
| 11 | 1238 |  | Free Text | A PA is not required for those 6 years of age and older. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |