MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy
CNS Stimulants and Psychotherapeutic Agents

Table of Contents

Policy Number: 019

BCBSA Reference Number: N/A

Related Policies

- Quality Care Dosing guidelines may apply to the following medications and can be found in Medical Policy #621A.

Prior Authorization Information

Policy	☒ Prior Authorization ☐ Step Therapy ☒ Quantity Limit ☐ Administrative	Reviewing Department	**Pharmacy Operations:** Tel: 1-800-366-7778 Fax: 1-800-583-6289
		Policy Effective Date	**4/2024**
Pharmacy (Rx) or Medical (MED) benefit coverage	☒ Rx ☐ MED	**To request for coverage:** Providers may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below. **Blue Cross Blue Shield of Massachusetts** **Pharmacy Operations Department** 25 Technology Place Hingham, MA 02043 Tel: 1-800-366-7778 Fax: 1-800-583-6289 **Individual Consideration for the atypical patient:** Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration	
Policy applies to Commercial Members: • Managed Care (HMO and POS), • PPO and Indemnity • MEDEX with Rx plan • Managed Major Medical with Custom BCBSMA Formulary • Comprehensive Managed Major Medical with Custom BCBSMA Formulary • Managed Blue for Seniors with Custom BCBSMA Formulary **Policy does NOT apply to**: • Medicare Advantage			

Summary

This is a comprehensive policy covering prior authorization and quantity limit requirements for CNS Stimulants and Psychotherapeutic Agents.

Formulary status/requirements of medications affected by this policy are provided in below:

Drug	Formulary Status (BCBSMA Commercial Plan)	Requirement
amphetamine	Covered, PA	PA required. See criteria below

armodafinil	Covered, PA	
dextroamphetamine	Covered, PA	
dextroamphetamine ER	Covered, PA	
Desoxyn ® (methamphetamine)	Covered, PA	
Methamphetamine	Covered, PA	
modafinil	Covered, PA	
Zenzedi ® (dextroamphetamine)	Covered, PA	
Dexedrine ® (dextroamphetamine)	NFNC, PA	PA required and meet Non-formulary exception criteria
Dexedrine Spansules ® (dextroamphetamine)	NFNC, PA	
Evekeo ™ (amphetamine sulfate)	NFNC, PA	
Evekeo ODT ™ (amphetamine sulfate)	NFNC, PA	
Sunosi ® (solriamfetol)	NFNC, PA	
Wakix ® (pitolisant)	NFNC, PA, QCD	

PA – Prior Authorization; NFNF – Non-formulary, non-covered; QCD – Quality Care Dosing (refer to policy #621b)

Policy

Length of Approval	12 months
Formulary Status	All requests must meet the Prior Authorizations requirement. For non-covered medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria

Amphetamine, Dexedrine ®/Dexedrine ® Spansules, Desoxyn ®, and Zenzedi ®

Amphetamine, Dexedrine /Dexedrine Spansules, Desoxyn, Zenzedi and their generic alternatives may be considered **MEDICALLY NECESSARY** and may be covered when ALL of the following criteria are met:

1. Age < 17 years, **OR**
2. Age ≥ 17 years WITH a diagnosis of attention-deficit hyperactivity disorder (ADHD) or narcolepsy, **OR**
3. Prescribed by a board certified/board eligible Psychiatrist, Neurologist, Oncologist, or Sleep Medicine specialist, **OR**
4. Prior use of amphetamine, dextroamphetamine or methamphetamine

NOTE: Amphetamine is NOT covered for Exogenous Obesity according to our subscriber certificates.

Evekeo ™and Evekeo ODT

Evekeo and Evekeo ODT tablets may be considered **MEDICALLY NECESSARY** and may be covered when ALL of the following criteria are met:

1. Diagnosis of attention-deficit hyperactivity disorder (ADHD) or Narcolepsy, **AND**
2. Prescribed by a board certified/board eligible Psychiatrist, Neurologist, Oncologist, or Sleep Medicine specialist, **AND**

3. Previous use of TWO covered formulary alternatives (ex: amphetamine salt combination, dextroamphetamine, methylphenidate, Metadate ER)

NOTE: Evekeo is NOT covered for Exogenous Obesity according to our subscriber certificates

Modafinil

Modafinil may be considered **MEDICALLY NECESSARY** and may be covered when ALL of the following criteria are met:

1. Age ≥18 years; **AND**
2. A diagnosis of narcolepsy, obstructive sleep apnea/hypopnea syndrome, or shift work sleep disorder, **AND**
3. Prescribed by a board certified/board eligible Psychiatrist, Neurologist, Oncologist, or Sleep Medicine specialist,

OR

4. Prior claim history of modafinil

Armodafinil

Armodafinil may be considered **MEDICALLY NECESSARY** and may be covered when ALL of the following criteria are met:

1. Age ≥18 years; **AND**
2. A diagnosis of narcolepsy, obstructive sleep apnea/hypopnea syndrome, or shift work sleep disorder, **AND**
3. Prescribed by a board certified/board eligible Psychiatrist, Neurologist, Oncologist, or Sleep Medicine specialist,

OR

4. Prior claim history of armodafinil

Sunosi

Sunosi may be considered **MEDICALLY NECESSARY** and may be covered when ALL of the following criteria are met:

1. Age ≥ 18 years, **AND**
2. A diagnosis of narcolepsy or obstructive sleep apnea/hypopnea syndrome, **AND**
3. Prescribed by a board certified/board eligible Psychiatrist, Neurologist, Oncologist, or Sleep Medicine specialist, **AND**
4. Prior claim history of modafinil **AND** armodafinil

Wakix

Wakix may be considered **MEDICALLY NECESSARY** and may be covered when ALL of the following criteria are met:

1. Age ≥ 18 years, **AND**
2. A diagnosis of narcolepsy or cataplexy, **AND**
3. Prescribed by a board certified/board eligible Psychiatrist, Neurologist, Oncologist, or Sleep Medicine specialist, **AND**
4. For diagnosis of narcolepsy only, prior claim history of modafinil AND armodafinil

Note: * Diagnosis of cataplexy diagnosis does NOT require the prior use of modafinil and armodafinil

Prior Use Criteria

The plan uses prescription claim records to support criteria for prior use within previous 130 days or the trial and failure of formulary alternatives when available. Additional documentation will be required from the provider when historic prescription claim data is either not available or the medication fill history fails to establish criteria for prior use or trial and failure of formulary alternatives. Documentation will also be required to support any clinical reasons preventing the trial and failure of formulary alternatives. Please see the section on documentation requirements for more information.

Provider Documentation Requirements

Documentation from the provider to support a reason preventing trial of formulary alternative(s) must include the name and strength of alternatives tried and failed (if alternatives were tried, including dates if available) and specifics regarding the treatment failure. Documentation to support clinical basis preventing switch to formulary alternative should also provide specifics around clinical reason.

Individual Consideration (For Atypical Patients)

Our medical policies are written for most people with a given condition. Each policy is based on peer reviewed clinical evidence. We also take into consideration the needs of atypical patient populations and diagnoses.

If the coverage criteria outlined is unlikely to be clinically effective for the prescribed purpose, the health care provider may request an exception to cover the requested medication based on an individual's unique clinical circumstances. This is also referred to as "individual consideration" or an "exception request."

Some reasons why you may need us to make an exception include: therapeutic contraindications; history of adverse effects; expected to be ineffective or likely to cause harm (physical, mental, or adverse reaction).

To facilitate a thorough and prompt review of an exception request, we encourage the provider to include additional supporting clinical documentation with their request. This may include:

- Clinical notes or supporting clinical statements;
- The name and strength of formulary alternatives tried and failed (if alternatives were tried) and specifics regarding the treatment failure, if applicable;
- Clinical literature from reputable peer reviewed journals;
- References from nationally recognized and approved drug compendia such as American Hospital Formulary Service® Drug Information (AHFS-DI), Lexi-Drug, Clinical Pharmacology, Micromedex or Drugdex®; and
- References from consensus documents and/or nationally sanctioned guidelines.

Providers may call, fax or mail relevant clinical information, including clinical references for individual patient consideration, to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Phone: 1-800-366-7778
Fax: 1-800-583-6289

We may also use prescription claims records to establish prior use of formulary alternatives or to show if step therapy criteria has been met. We will require the provider to share additional information when prescription claims data is either not available or the medication fill history fails to establish use of preferred formulary medications or that step therapy criteria has been met.

Policy History

Date	Action
4/2024	Update criteria for armodafinil and modafinil.
1/2024	Clarified coding for Wakix and Sunosi.
11/2023	Reformatted Policy.
10/2023	Reformatted Policy and updated IC to align with 118E MGL § 51A.
7/2023	Reformatted Policy.
4/2022	Updated armodafinil criteria to remove trial of modafanil and removed Nuvigil & Provigil as they will be handled with Formulary Exception criteria.
1/2021	Updated to add new indication for Wakix®.
1/2020	Updated to remove PA on atomoxetine and Straterra™ and make Straterra™ not covered and add Wakix® and Sunosi™ to the policy.
2/2019	Updated to add Amphetamine to the policy.
7/2018	Clarified coding for Provigil.
1/2018	Updated to include atomoxetine & criteria for Straterra™.
6/2017	Update address for Pharmacy Operations.
11/2016	Updated to include armodafinil and Evekeo.
7/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
4/2014	Updated to include Sleep Medicine specialists.
2/2014	Updated ExpressPAth language, remove Blue Value and added Zenzedi.
6/2012	Updated to include coverage criteria for new generic modafanil.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
2/2012	Reviewed – Medical Policy Group – Psychiatry and Ophthalmology. No changes to policy statements.
1/2012	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
5/2011	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
2/2011	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2011	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
5/2010	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
2/2010	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2010	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
11/2009	Updated to include authorization requirements for Nuvigil™.
9/2009	Policy updated to change 180 day look back period to 130 days, update sample language, define coverage for new starts, and to remove Medicare Part D criteria from Medical Policy.
5/2009	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
2/2009	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2009	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
5/2008	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
2/2008	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2008	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
5/2007	Reviewed - Medical Policy Group - Pediatrics and Endocrinology.

	No changes to policy statements.
2/2007	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2007	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
11/2004	New policy, effective 11/2004, describing covered and non-covered indications.

Forms

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

https://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf

OR

Print and fax, Massachusetts Standard Form for Medication Prior Authorization Requests #434

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