

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS

METHYLPHENIDATE PRODUCTS

**BRAND NAME
(generic)**

APTENSIO XR
(methylphenidate extended-release)

CONCERTA
(methylphenidate extended-release)

DAYTRANA
(methylphenidate transdermal system)

FOCALIN PRODUCTS
(dexmethylphenidate)

JORNAY PM
(methylphenidate extended-release)

METADATE PRODUCTS
(methylphenidate)

METHYLIN PRODUCTS
(methylphenidate)

(methylphenidate osmotic extended-release)

QUILLICHEW ER
(methylphenidate extended-release chewable tablets)

QUILLIVANT XR
(methylphenidate hydrochloride extended-release oral suspension)

RITALIN PRODUCTS
(methylphenidate)

Status: Client Requested Criteria

Type: Initial Prior Authorization with Quantity Limit

Ref # C10389-C

CRITERIA FOR APPROVAL

1	Does the patient have a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? [If no, then skip to question 3.]	Yes	No
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2	Has the diagnosis been appropriately documented (i.e., evaluated by a complete clinical assessment, using DSM-5, standardized rating scales, interviews/questionnaires)? [If yes, then skip to question 11.]	Yes	No
3	Does the patient have the diagnosis of narcolepsy confirmed by a sleep study? [If no, then skip to question 8.]	Yes	No
4	Is this request for a dexamethylphenidate product (Focalin, Focalin XR) or QuilliChew ER?	Yes	No
5	Which drug is being requested (applies to brand or generic)? [Note: Please check which drug (applies to brand or generic).] <input type="checkbox"/> Aptensio XR (methylphenidate extended-release) (if checked, go to 6) <input type="checkbox"/> Concerta, Methylphenidate Osmotic Extended-Release (methylphenidate extended-release) (if checked, go to 6) <input type="checkbox"/> Daytrana Patch (methylphenidate transdermal system) (if checked, go to 15) <input type="checkbox"/> Jornay PM (methylphenidate extended-release) (if checked, go to 6) <input type="checkbox"/> Metadate CD (methylphenidate extended-release) (if checked, go to 6) <input type="checkbox"/> Methylin chewable (methylphenidate chewable tablet) (if checked, go to 7) <input type="checkbox"/> Ritalin (methylphenidate tablets) (if checked, go to 7) <input type="checkbox"/> Methylin oral solution (methylphenidate oral solution) (if checked, go to 7) <input type="checkbox"/> methylphenidate extended-release (if checked, go to 6) <input type="checkbox"/> Quillivant XR (methylphenidate hydrochloride extended-release oral suspension) (if checked, go to 6) <input type="checkbox"/> Ritalin LA (methylphenidate extended-release) (if checked, go to 6)		
6	Does the patient require use of MORE than any of the following: A) 90 units per month of methylphenidate ER 10 mg, 20 mg, B) 60 units per month of Aptensio XR 10 mg, 15 mg, 20 mg, 30 mg OR Concerta 18 mg, 27 mg, 36 mg OR Jornay PM 20 mg, 40 mg OR Metadate CD 10 mg, 20 mg, 30 mg OR Ritalin LA 10 mg, 20 mg, 30 mg, C) 30 units per month of Aptensio XR 40 mg, 50 mg, 60 mg OR Concerta 54 mg OR Jornay PM 60 mg, 80 mg, 100 mg OR Metadate CD 40 mg, 50 mg, 60 mg OR methylphenidate osmotic extended-release 72 mg OR Ritalin LA 40 mg, 60 mg, D) 360 ml per month of Quillivant XR oral suspension 25 mg/5 ml (5 mg/ml)? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval per the Quantity Limit Chart for narcolepsy.]	Yes	No
7	Does the patient require use of MORE than any of the following: A) 180 units per month of Methylin chewable tablets 2.5 mg, 5 mg, 10 mg OR methylphenidate 5 mg, 10 mg (generic Ritalin), B) 90 units per month of methylphenidate 20 mg (generic Ritalin), D) 1,800 ml per month of methylphenidate oral solution 5 mg/5 ml (generic Methylin oral solution), E) 900 ml per month of methylphenidate oral solution 10 mg/5ml (generic Methylin oral solution)? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval per the Quantity Limit Chart for narcolepsy.]	Yes	No
8	Does the patient have a diagnosis of idiopathic hypersomnia confirmed by polysomnography? [If yes, then skip to question 11.]	Yes	No

9	Does the patient have a diagnosis of fatigue associated with Multiple Sclerosis (MS)?	Yes	No
10	Have other causes of fatigue, tiredness, or decreased energy been evaluated and treated if necessary?	Yes	No
11	Which drug is being requested (applies to brand or generic)? [Note: Please check which drug (applies to brand or generic).] <input type="checkbox"/> Aptensio XR (methylphenidate extended-release) (if checked, go to 12) <input type="checkbox"/> Concerta, Methylphenidate Osmotic Extended-Release (methylphenidate extended-release) (if checked, go to 12) <input type="checkbox"/> Daytrana Patch (methylphenidate transdermal system) (if checked, go to question 15) <input type="checkbox"/> Focalin (dexmethylphenidate) (if checked, go to 13) <input type="checkbox"/> Focalin XR (dexmethylphenidate extended-release) (if checked, go to 13) <input type="checkbox"/> Jornay PM (methylphenidate extended-release) (if checked, go to 12) <input type="checkbox"/> Metadate CD (methylphenidate extended-release) (if checked, go to 12) <input type="checkbox"/> Methylin chewable (methylphenidate chewable tablet) (if checked, go to 14) <input type="checkbox"/> Ritalin (methylphenidate tablets) (if checked, go to 14) <input type="checkbox"/> Methylin oral solution (methylphenidate oral solution) (if checked, go to 14) <input type="checkbox"/> methylphenidate extended-release (if checked, go to 12) <input type="checkbox"/> QuilliChew ER (methylphenidate extended-release chewable tablets) (if checked, go to 12) <input type="checkbox"/> Quillivant XR (methylphenidate hydrochloride extended-release oral suspension) (if checked, go to 12) <input type="checkbox"/> Ritalin LA (methylphenidate extended-release) (if checked, go to 12)		
12	Does the patient require use of MORE than any of the following: A) 150 units per month of methylphenidate ER 10 mg, 20 mg OR QuilliChew ER 20 mg OR Ritalin LA 10 mg, 20 mg, B) 90 units per month of Aptensio XR 10 mg, 15 mg, 20 mg, 30 mg OR Concerta 18 mg, 27 mg, 36 mg OR Metadate CD 10 mg, 20 mg, 30 mg OR QuilliChew ER 30 mg OR Ritalin LA 30 mg, C) 60 units per month of Aptensio XR 40 mg, 50 mg OR Concerta 54 mg OR Jornay PM 20 mg, 40 mg OR Metadate CD 40 mg, 50 mg OR QuilliChew ER 40 mg OR Ritalin LA 40 mg, D) 30 units per month of Aptensio XR 60 mg OR Jornay PM 60 mg, 80 mg, 100 mg OR Metadate CD 60 mg OR Methylphenidate Osmotic Extended-Release 72 mg OR Ritalin LA 60 mg, E) 600 ml per month of Quillivant XR oral suspension 25 mg/5 ml (5 mg/1 ml)? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval per the Quantity Limit Chart for ADHD/Idiopathic Hypersomnia/MS Fatigue.]	Yes	No
13	Does the patient require use of MORE than any of the following: A) 150 tablets per month of Focalin 2.5 mg, 5 mg, 10 mg, B) 90 units per month of Focalin XR 5 mg, 10 mg, 15 mg, C) 60 capsules per month of Focalin XR 20 mg, 25 mg, D) 30 capsules per month of Focalin XR 30 mg, 35 mg or 40 mg? [No further questions.] [RPh Note: If yes, then deny and enter a partial approval per the Quantity Limit Chart for ADHD/Idiopathic Hypersomnia/MS Fatigue.]	Yes	No
14	Does the patient require use of MORE than any of the following: A) 300 units per month of Methylin chewable tablets 2.5 mg, 5 mg, 10 mg, B) 210 units per month of methylphenidate 5 mg, 10 mg (generic Ritalin), C) 150 units per month of	Yes	No

methylphenidate 20 mg (generic Ritalin), D) 3,000 ml per month of methylphenidate oral solution 5 mg/5 ml (generic Methylin oral solution), E) 1,500 ml per month of methylphenidate oral solution 10 mg/5ml (generic Methylin oral solution)?
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval per the Quantity Limit Chart for ADHD/Idiopathic Hypersomnia/MS Fatigue.]

15 Does the patient require use of MORE than 30 patches per month of Daytrana Patch? Yes No
[No further questions.]

[RPh Note: If yes, then deny and enter a partial approval for 30 patches per month of Daytrana Patch.]

Mapping Instructions

	Yes	No
1.	Go to 2	Go to 3
2.	Go to 11	Deny
3.	Go to 4	Go to 8
4.	Deny	Go to 5
5.	1=6; 2=6; 3=15; 4=6; 5=6; 6=7; 7=7; 8=7; 9=6; 10=6; 11=6	N/A
6.	Deny	Approve, 36 months, see Quantity Limit Chart for Narcolepsy
7.	Deny	Approve, 36 months, see Quantity Limit Chart for Narcolepsy
8.	Go to 11	Go to 9
9.	Go to 10	Deny
10.	Go to 11	Deny
11.	1=12; 2=12; 3=15; 4=13; 5=13; 6=12; 7=12; 8=14; 9=14; 10=14; 11=12; 12=12; 13=12; 14=12	N/A
12.	Deny	Approve, 36 months, see Quantity Limit Chart for ADHD/Idiopathic Hypersomnia/MS Fatigue
13.	Deny	Approve, 36 months, see Quantity Limit Chart for ADHD/Idiopathic Hypersomnia/MS Fatigue
14.	Deny	Approve, 36 months, see Quantity Limit Chart for ADHD/Idiopathic Hypersomnia/MS Fatigue
15.	Deny	Approve, 36 months, see Quantity Limit Chart for ADHD/Idiopathic Hypersomnia/MS Fatigue

REFERENCES

1. NCSHP Prior Authorization Approval Policy.

Written by: UM Development (CT)
Date Written: 04/2017
Revised: (KC) 02/2018, 10/2018
Reviewed: Medical Affairs: (MA) 05/2017, (CW) 05/2018, (GAD) 11/2018

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

Methylphenidate NCSHP C10389-C 10-2018.docx

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Signature

Date

Client Name

Quantity for Approval - Quantity Chart for ADHD/Idiopathic Hypersomnia/MS Fatigue		
Drug	Quantity/25 days*	Quantity/75 days*
Aptensio XR 10 mg, 15 mg, 20 mg, 30 mg	90 capsules	270 capsules
Aptensio XR 40 mg, 50 mg	60 capsules	180 capsules
Aptensio XR 60 mg	30 capsules	90 capsules
Concerta 18 mg, 27 mg, 36 mg	90 tablets	270 tablets
Concerta 54 mg	60 tablets	180 tablets
Daytrana Patch 10 mg, 15 mg, 20 mg, 30 mg	30 patches	90 patches
Focalin 2.5 mg, 5 mg, 10 mg	150 tablets	450 tablets
Focalin XR 5 mg, 10 mg, 15 mg	90 capsules	270 capsules
Focalin XR 20 mg, 25 mg	60 capsules	180 capsules
Focalin XR 30 mg, 35 mg, 40 mg	30 capsules	90 capsules
Jornay PM 20 mg, 40 mg	60 capsules	180 capsules
Jornay PM 60 mg, 80 mg, 100 mg	30 capsules	90 capsules
Metadate CD 10 mg, 20 mg, 30 mg	90 capsules	270 capsules
Metadate CD 40 mg, 50 mg	60 capsules	180 capsules
Metadate CD 60 mg	30 capsules	90 capsules
Methylin chewable tablets 2.5 mg, 5 mg, 10 mg	300 tablets	900 tablets
Methylphenidate 5 mg, 10 mg	210 tablets	630 tablets
Methylphenidate 20 mg	150 tablets	450 tablets
Methylphenidate oral solution 5 mg/5 ml	3,000 ml	9,000 ml
Methylphenidate oral solution 10mg/5ml	1,500 ml	4,500 ml
Methylphenidate osmotic ER 72 mg	30 tablets	90 tablets
Methylphenidate ER 10 mg, 20 mg	150 tablets	450 tablets
QuilliChew ER 20 mg	150 tablets	450 tablets
QuilliChew ER 30 mg	90 tablets	270 tablets
QuilliChew ER 40 mg	60 tablets	180 tablets
Quillivant XR oral suspension 25 mg/5 mL (5 mg/1 ml)	600 ml	1,800 ml
Ritalin LA 10 mg, 20 mg	150 capsules	450 capsules
Ritalin LA 30 mg	90 capsules	270 capsules
Ritalin LA 40 mg	60 capsules	180 capsules
Ritalin LA 60 mg	30 capsules	90 capsules

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

Quantity for Approval - Quantity Chart for Narcolepsy		
Drug	Quantity/25 days*	Quantity/75 days*
Aptensio XR 10 mg, 15 mg, 20 mg, 30 mg	60 capsules	180 capsules
Aptensio XR 40 mg, 50 mg, 60 mg	30 capsules	90 capsules
Concerta 18 mg, 27 mg, 36 mg	60 tablets	180 tablets
Concerta 54 mg	30 tablets	90 tablets

Daytrana Patch 10 mg, 15 mg, 20 mg, 30 mg	30 patches	90 patches
Jornay PM 20 mg, 40 mg	60 capsules	180 capsules
Jornay PM 60 mg, 80 mg, 100 mg	30 capsules	90 capsules
Metadate CD 10 mg, 20 mg, 30 mg	60 capsules	180 capsules
Metadate CD 40 mg, 50 mg, 60 mg	30 capsules	90 capsules
Methylin chewable tablets 2.5 mg, 5 mg, 10 mg	180 tablets	540 tablets
Methylphenidate 5 mg, 10 mg	180 tablets	540 tablets
Methylphenidate 20 mg	90 tablets	270 tablets
Methylphenidate oral solution 5 mg/5 ml	1,800 ml	5,400 ml
Methylphenidate oral solution 10mg/5ml	900 ml	2,700 ml
Methylphenidate osmotic ER 72 mg	30 tablets	90 tablets
Methylphenidate ER 10 mg, 20 mg	90 tablets	270 tablets
Quillivant XR oral suspension 25 mg/5 mL (5 mg/1 ml)	360 ml	1080 ml
Ritalin LA 10 mg, 20 mg, 30 mg	60 capsules	180 capsules
Ritalin LA 40 mg, 60 mg	30 capsules	90 capsules
<i>*The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.</i>		