PRIOR AUTHORIZATION CRITERIA

BRAND NAME (generic)

STRATTERA (atomoxetine hydrochloride)

Status: Client Requested Criteria

Type: Initial Prior Authorization with Quantity Limit Ref # C10390-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 4.]	Yes	No		
2	Will the patient be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior?	Yes	No		
3	Does the patient require use of MORE than any of the following: A) 120 capsules per month of Strattera 10 mg, 18 mg, 25 mg, B) 60 capsules per month of Strattera 40 mg, C) 30 capsules per month of Strattera 60 mg, 80 mg, 100 mg? [No further questions.]	Yes	No		
	[Rph Note: If yes, then deny and enter a partial approval for ONE of the following:) 120 capsules per month of Strattera 10 mg, 18 mg, 25 mg, B) 60 capsules per month of Strattera 40 mg, C) 30 capsules per month of Strattera 60 mg, 80 mg, 100 mg.]				
4	Does the patient have a diagnosis of idiopathic hypersomnia confirmed by polysomnography? [If yes, then skip to question 6.]	Yes	No		
5	Does the patient have a diagnosis of fatigue associated with Multiple Sclerosis (MS)?	Yes	No		
6	Does the patient require use of MORE than any of the following: A) 120 capsules per month of Strattera 10 mg, 18 mg, 25 mg, B) 60 capsules per month of Strattera 40 mg, C) 30 capsules per month of Strattera 60 mg, 80 mg, 100 mg?	Yes	No		
	[Rph Note: If yes, then deny and enter a partial approval for ONE of the following:) 120 capsules per month of Strattera 10 mg, 18 mg, 25 mg, B) 60 capsules per month of Strattera 40 mg, C) 30 capsules per month of Strattera 60 mg, 80 mg, 100 mg.]				

Mapping Instructions					
	Yes	No			
1.	Go to 2	Go to 4			
2.	Go to 3	Deny			
3.	Deny	Approve, 36 months:			
		Strattera 10 mg, 18 mg, 25 mg: 120 capsules/month			
		Strattera 40 mg: 60 capsules/month			
		Strattera 60 mg, 80 mg, 100 mg: 30 capsules/month			

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4.	Go to 6	Go to 5	
5.	Go to 6	Deny	
6.	Deny	Approve, 12 months:	
		Strattera 10 mg, 18 mg, 25 mg: 120 capsules/month	
		Strattera 40 mg: 60 capsules/month	
		Strattera 60 mg, 80 mg, 100 mg: 30 capsules/month	

REFERENCES

1. NCSHP Prior Authorization Approval Policy.

Written by: Date Written: UM Development (CT) 04/2017

Revised: (KC) 02/2018

Medical Affairs: (MA) 05/2017, (CW) 05/2018 Reviewed:

The Participating Group signed below hereby accepts and adopt as administered by CVS Caremark.	s as its own the criteria for use with Prior Authorization
Signature	Date
Client Name	-

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