



## Missouri Pharmacy Program – Preferred Drug List



### ADHD Non-Stimulant Agents

Effective 01/10/2019

Revised 01/09/2020

#### Preferred Agents

- Atomoxetine
- Clonidine ER
- Guanfacine ER

#### Non-Preferred Agents

- Intuniv®
- Kapvay™
- Strattera®

### Approval Criteria

- Dosage within approved dosage limitations **AND**
- Participant demonstrates compliance to prescribed therapy **OR**
- Failure to achieve desired therapeutic outcomes with trial on **2** or more preferred agents
  - Documented trial period for preferred agents (90 out of 120 days) **OR**
  - Documented ADE/ADR to preferred agents
- Participant aged ≥ 6 years and < 18 years: appropriate diagnosis of ADHD
- Participant aged ≥ 18 years and < 23 years:
  - Appropriate diagnosis of ADHD
  - Goals of therapy clearly defined by prescriber (may include academic/work enrollment)
- Participant aged > 23 years: appropriate diagnosis of ADHD:
  - Confirmed diagnosis of ADHD using DSM-5 Diagnostic Criteria - Attention-Deficit/Hyperactivity Disorder (ADHD) **AND**
  - Completion of an adult ADHD self-rating scale confirming diagnosis **AND**
  - Documentation of symptoms occurring in 2 or more settings **AND**
  - Clear evidence that the symptoms interfere with social, academic or occupational functioning **AND**
  - Goals of therapy clearly defined by prescriber
  - Claim flagged for clinical consultant review secondary to concomitant psychiatric medication use of 3 or more agents (including requested ADHD therapy)
  - Claim flagged if concomitant use of benzodiazepines present
  - Psychiatric Specialist Consult (within most recent 6 months) required for diagnosis and treatment initiation (participant may receive regular follow-up by primary care physician)
  - Adequate trial required for monotherapy

### Denial Criteria

- Lack of adequate trial on required preferred agents
- Therapy will be denied if no approval criteria are met
- Participant aged < 6 years
- Drug Prior Authorization Hotline: (800) 392-8030