



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Methylphenidate Products

Page: 1 of 4

Effective Date: 12/4/2023

Last Review Date: 8/2023

Applies to:	<input checked="" type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for methylphenidate products under the patient's prescription drug benefit.

Description:

Adhansia XR, Aptensio XR, Jornay PM

These products are indicated for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD) in patients 6 years and older.

Concerta, Methylphenidate Osmotic ER

These products are indicated for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD) in children 6 years of age and older, adolescents, and adults up to the age of 65.

Cotempla XR-ODT

Cotempla XR-ODT is indicated for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD) in pediatric patients 6 to 17 years of age.

Daytrana, Focalin, Focalin XR, Methylphenidate CD, QuilliChew ER, Quillivant XR

These products are indicated for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD).

Methylphenidate Chewable Tablets

Attention Deficit Disorders

Narcolepsy

Methylphenidate, Methylphenidate Extended Release, Methylin Oral Solution, Ritalin, Ritalin SR

Attention Deficit Hyperactivity Disorder (ADHD) in adults and pediatric patients 6 years of age and older.

Narcolepsy

Relexxii

Relexxii is indicated for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD) in adults (up to the age of 65 years) and pediatric patients 6 years of age and older.

Ritalin LA



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Ritalin LA is indicated for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD) in pediatric patients 6 to 12 years of age.

Compendial Uses

Narcolepsy

Cancer-related fatigue

Applicable Drug List:

Reference Non-Preferred drugs and Preferred with Prior Authorization drugs on the Illinois Medicaid Preferred Drug List

Policy/Guideline:

Documentation for Initial Requests for all indications:

For non-preferred medication requests, the patient is unable to take three (3) formulary alternatives for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) **AND**
 - The diagnosis has been appropriately documented (e.g., evaluated by a complete clinical assessment, using DSM-5, standardized rating scales, interviews/questionnaires) **AND**
 - The patient is 6 years of age or older**OR**
 - The patient is 5 years of age or younger**AND**
 - The patient continues to have ADHD/ADD (Attention-Deficit/Hyperactivity Disorder or Attention Deficit Disorder) symptoms despite participating in evidence-based behavioral therapy (e.g., parent training in behavior management (PTBM), behavioral classroom interventions)
- OR**
- The request is for continuation of therapy
- AND**



AETNA BETTER HEALTH®
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- The patient has achieved or maintained improvement in their signs and symptoms of ADHD/ADD (Attention-Deficit/Hyperactivity Disorder or Attention Deficit Disorder) from baseline

AND

- The patient’s need for continued therapy has been assessed within the previous year

OR

- The patient has a diagnosis of narcolepsy

AND

- The requested drug is being prescribed by, or in consultation with, a sleep specialist

AND

- The diagnosis has been confirmed by a sleep study

OR

- The request is for continuation of therapy

AND

- The patient has achieved or maintained improvement in daytime sleepiness with narcolepsy from baseline

OR

- The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out

AND

- The request is for initial therapy

OR

- The request is for continuation of therapy

AND

- The patient has achieved or maintained improvement in cancer-related fatigue from baseline

AND

- The patient’s need for continued therapy has been assessed within the previous year

Approval Duration and Quantity Restrictions:

Approval:

Attention-Deficit Hyperactivity Disorder (ADHD) or Attention-Deficit Disorder (ADD):
Approve 12 months



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Narcolepsy: Approve 12 months

Cancer-related fatigue: Approve 12 months

Quantity Level Limit: Reference formulary for drug specific quantity level limits

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