Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 7/31/2018**
Policy Number: PA.CP.PMN.01	**Effective Date: 01/2018** **Revision Date: 07/18/2018**
Policy Name: Atomoxetine (Strattera)	**HC Approval Date:**

Type of Submission – Check all that apply:

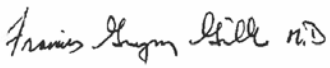
- ☐ **New Policy**
- ☐ **Revised Policy***
- ☐ **Annual Review – No Revisions**
- ☐ **Attestation of HC PARP Policy** – *This option should only be used during Readiness Review for Community HealthChoices. The policy must be identical to the PARP approved policy for the HealthChoices Program, with the exception of revisions/clarifications adding the term "Community HealthChoices" to the policy.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

This policy is being retired and replaced by the following policy:

- **PA.CP.PST.17 Atomoxetine (Strattera)**

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:** 

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Clinical Policy: Atomoxetine (Strattera)

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Reference Number: PA.CP.PMN.01
Effective Date: 01/18
Last Review Date: 02/17
Line of Business: Medicaid

Coding Implications
Revision Log

Description
Atomoxetine (Strattera®) is a selective norepinephrine reuptake inhibitor.

FDA approved indication
Strattera is indicated for

- Treatment of attention-deficit/hyperactivity disorder (ADHD)

Policy/Criteria
** Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria **
Prior authorization may be required for amphetamine and methylphenidate products for adult members

It is the policy of Pennsylvania Health and Wellness ® that Strattera is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Attention-Deficit/Hyperactivity Disorder (ADHD)(must meet all)**:**

1. Diagnosis of ADHD or attention-deficit disorder (ADD);
2. Age ≥ 6 years;
3. Member meets one of the following (a or b):
   a. Failure of one amphetamine and one methylphenidate at maximum indicated doses, each trialed for ≥ 2 weeks, unless member experiences clinically significant adverse effects or has contraindication(s) to all amphetamine and methylphenidate products;
   b. Member or parent/guardian of member has a history of substance abuse
4. Request does not exceed 100 mg/day.

Approval duration: 12 months

B. Other diagnoses/indications – Refer to PA.CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

II. Continued Therapy

A. Attention-Deficit/Hyperactivity Disorder (ADHD) (must meet all)**:**

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 100 mg/day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Pennsylvania Health and Wellness benefit and documentation supports positive response to therapy or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies; or
2. Refer to PA.CP.PMN.53 if requested indication is NOT listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

Approval duration: 12 months

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – PA.CP.PMN.53 or evidence of coverage documents

IV. Appendices/General Information

Appendix A: Abbreviation Key
ADD: attention-deficit disorder
ADHD: attention-deficit/hyperactivity disorder
FDA: Food and Drug Administration

V. Dosage and Administration

Body Weight	Initial Daily Dose	Target Total Daily Dose	Maximum Total Daily Dose
Children and adolescents up to 70 kg	0.5 mg/kg	1.2 mg/kg	1.4 mg/kg
Children and adolescents over 70 kg and adults	40 mg	80 mg	100 mg

Strattera is recommended to be dosed once or twice daily.

VI. Product Availability

Capsules: 10 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg, or 100 mg

VII. References

1. Strattera Prescribing Information. Indianapolis, IN: Eli Lilly and Company; April 2015. Available at: https://www.lilly.com/Products/Human/Our-Current-Products.aspx. Accessed November 10, 2016.
2. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with Attention-Deficit/Hyperactivity Disorder. J Am Acad Child Adolesc Psychiatry. 2007;46(7):894-921.
3. American Academy of Pediatrics subcommittee on attention-deficit/hyperactivity disorder, steering committee on quality improvement and management. ADHD: clinical

practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. Pediatrics 2011;128(5):1007-1022.

Reviews, Revisions, and Approvals	Date	Approval Date
This policy is being retired and replaced by **PA.CP.PST.17 Atomoxetine (Strattera)**	7/18	

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