MASSACHUSETTS

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Pharmacy Medical Policy

CNS Stimulants and Psychotherapeutic Agents

Table of Contents

Policy Number: 019

BCBSA Reference Number: None

Related Policies

- Quality Care Dosing guidelines may apply to the following medications and can be found in Medical Policy #621A.

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary status of the medications affected by this policy.

Drug	Formulary Information
	Standard
	Formulary Status
Amphetamine	PA required
Armodafinil	PA required
Dextroamphetamine	PA required
Desoxyn ® (methamphetamine)	PA required
Dexedrine ® ##(dextroamphetamine)	Not Covered
Dexedrine ® ##**Spansules** (dextroamphetamine)	Not Covered
Evekeo ™## (amphetamine sulfate)	Not Covered
Evekeo ™## **ODT** (amphetamine sulfate)	Not Covered
Methamphetamine	PA required
Modafanil	PA required

Drugs__Continued	Formulary Information
	Standard
	Formulary Status
Sunosi ## **(**solriamfetol**)**	Not Covered
Wakix ## **(**pitolisant**)**	Not Covered
Zenzedi ® (dextroamphetamine)	PA required

##- Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and requires **TWO** formulary drugs to be tried prior to granting a Formulary Exception (FE).

We may cover the following CNS Stimulants and Psychotherapeutic Agents listed in the chart above for new starts* in the following stepped approach:

*New start is defined as no previous paid claim for the requested medication within the past 130 days.

We may cover **Amphetamine** %%, **Dexedrine** ®/**Dexedrine** ® **Spansules** (dextroamphetamine), **Desoxyn** ® (methamphetamine), **Zenzedi** ® (dextroamphetamine), or generics when the patient meets the following criteria:

- The patient is < 17 years of age,
  OR
- The patient is ≥ 17 years of age and has a diagnosis of attention-deficit/ hyperactivity disorder (ADHD)or Narcolepsy,
  OR
- The prescription is written by a board certified / board eligible Psychiatrist, Neurologist, Oncologist, or Sleep Medicine specialist.
  OR
- The patient had prior use of amphetamine%%**,** dextroamphetamine or methamphetamine within the previous 130 days.

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

%% - Amphetamine is **NOT** covered for Exogenous Obesity.

We may cover **Evekeo** ™*# (amphetamine sulfate tablets) or **Evekeo**™*# (amphetamine sulfate) ODT tabs when the patient meets **All** of the following criteria:

- The patient has a diagnosis of attention-deficit/ hyperactivity disorder (ADHD) or Narcolepsy,
  AND
- The prescription is written by a board certified / board eligible Psychiatrist, Neurologist, Oncologist, or Sleep Medicine specialist.
  AND
- The member has satisfied the Formulary Exception criteria of trying and or failing two covered alternatives.

*# - We do not cover Evekeo ™ for Exogenous Obesity according to our subscriber certificates.

Note: If approved the Prior Authorization will be granted for up to one (1) year.

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

We may cover **Modafanil** when the patient meets the following criteria:

- Patient is < 17 years of age,
  OR
- Patient has a diagnosis of narcolepsy, obstructive sleep apnea / hypopnea syndrome, or shift work sleep disorder,
  OR
- The prescription is written by a board certified / board eligible Neurologist, Psychiatrist, Oncologist, or Sleep Medicine specialist.
  OR
- The patient had prior use of **Modafanil** within the previous 130 days.

We may cover **Armodafinil** when the patient meets the following criteria:

- Patient is < 17 years of age
  OR
- Patient has a diagnosis of narcolepsy, obstructive sleep apnea / hypopnea syndrome, or shift work sleep disorder
  OR
- The prescription is written by a board certified / board eligible Neurologist, Psychiatrist, Oncologist, or Sleep Medicine specialist
  OR
- The patient had prior use of **Armodafinil** within the previous 130 days.

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

We may cover **Sunosi** ## **(**solriamfetol**)** when the patient meets the following criteria:

- Patient is 18 years of age or older
  AND
- Patient has a diagnosis of narcolepsy or obstructive sleep apnea / hypopnea syndrome
  AND
- The prescription is written by a board certified / board eligible Neurologist, Psychiatrist, Oncologist, or Sleep Medicine specialist
  AND
- patient has tried and failed modafanil **AND** armodafinil within the previous 130 days

We may cover **Wakix** ## (pitolisant) when the patient meets the following criteria:

- Patient is 18 years of age or older
  AND
- Patient has a diagnosis of narcolepsy or cataplexy*%
  AND
- The prescription is written by a board certified / board eligible Neurologist, Psychiatrist, Oncologist, or Sleep Medicine specialist
  AND
- patient has tried and failed modafanil **AND** armodafinil within the previous 130 days

*% - Cataplexy diagnosis does not need to meet the covered alternative criteria

Note: If approved the Prior Authorization will be granted for up to one (1) year.

We do not cover the above drugs for other conditions not listed above.

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

CPT Codes / HCPCS Codes / ICD Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member. A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

There is no specific CPT code for this service.

Policy History

Date	Action
4/2022	Updated armodafinil criteria to remove trial of modafanil and removed Nuvigil & Provigil as they will be handled with Formulary Exception criteria.
1/2021	Updated to add new indication for Wakix®.
1/2020	Updated to remove PA on atomoxetine and Straterra™ and make Straterra™ not covered and add Wakix® and Sunosi™ to the policy.
2/2019	Updated to add Amphetamine to the policy.
7/2018	Clarified coding for Provigil.
1/2018	Updated to include atomoxetine & criteria for Straterra™.
6/2017	Update address for Pharmacy Operations.
11/2016	Updated to include armodafinil and Evekeo.
7/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
4/2014	Updated to include Sleep Medicine specialists.
2/2014	Updated ExpressPAth language, remove Blue Value and added Zenzedi.
6/2012	Updated to include coverage criteria for new generic modafanil.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.

2/2012	Reviewed – Medical Policy Group – Psychiatry and Ophthalmology. No changes to policy statements.
1/2012	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
5/2011	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
2/2011	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2011	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
5/2010	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
2/2010	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2010	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
11/2009	Updated to include authorization requirements for Nuvigil™.
9/2009	Policy updated to change 180 day look back period to 130 days, update sample language, define coverage for new starts, and to remove Medicare Part D criteria from Medical Policy.
5/2009	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
2/2009	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2009	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
5/2008	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
2/2008	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2008	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
5/2007	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
2/2007	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
1/2007	Reviewed - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
11/2004	New policy, effective 11/2004, describing covered and non-covered indications.

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To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf