ADHD Stimulant Step Therapy Program

Policy Number: 5.01.592  Last Review: 7/2019
Origination: 7/2017  Next Review: 7/2020

Policy

Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for brand name ADHD stimulant medications when the following criteria are met. The brand name ADHD medications affected are:

- Adderall XR® (mixed amphetamine salts [dextroamphetamine sulfate, dextroamphetamine saccharate, amphetamine sulfate, amphetamine aspartate] extended-release capsules – Shire US, generics)
- Adzenys XR-ODT™ (amphetamine extended-release orally disintegrating tablets – Neos Therapeutics)
- Aptensio XR™ (methylphenidate extended-release capsules – Rhodes)
- Concerta® (methylphenidate extended-release tablets – McNeil Pediatrics, generics)
- Daytrana® (methylphenidate transdermal system – Noven Pharmaceuticals)
- Dexedrine® Spansules® (dextroamphetamine sustained-release capsules – Amedra Pharmaceuticals, generics)
- Dyanavel™ XR (amphetamine extended-release oral suspension – Tris)
- Focalin® XR (dexamethesphenidate extended-release capsules – Novartis, generics)
- Metadate® CD (methylphenidate extended-release capsules – UCB, Inc., generics)
- Metadate® ER (methylphenidate sustained-release tablets – UCB, Inc., generic only)
- methylphenidate extended-release capsules (generics to discontinued Methylin™ ER)
- QuillChew ER™ (methylphenidate extended-release chewable tablets – Pfizer)
- Quillivant™ XR (methylphenidate extended-release oral suspension – NextWave)
- Ritalin® LA (methylphenidate extended-release capsules – Novartis, generics)
- Ritalin-SR® (methylphenidate sustained-release tablets – Novartis, generics)
- Vyvanse® (lisdexamfetamine dimesylate capsules – Shire US)

When Policy Topic is covered

A step therapy program has been developed to encourage use of one Step 1 product prior to the use of a Step 2 product. If the step therapy rule is not met for a Step 2 agent at the point of service, coverage will be determined by the step therapy criteria below. All approvals are provided for 1 year in duration.

Automation: Patients with a history of one Step 1 drug within the 130-day look-back period are excluded from step therapy.

Step 1:
Generic amphetamine/dextroamphetamine extended-release capsules (generics to Adderall XR),
generic dexamethesphenidate extended-release capsules (generics to Focalin XR), generic
dextroamphetamine extended-release capsules (generics to Dexedrine Spansules), generic
methylphenidate extended-release capsules (generics to Metadate CD and Ritalin LA), Metadate ER
(generic according to FDB), generic methylphenidate sustained-release tablets (generics to Ritalin SR),
generic methylphenidate extended-release tablets (generics to Concerta)
**Step 2:**
Adderall XR, Adzenys ER, Adzenys XR-ODT, Aptensio XR, Concerta, Cotempla XR-ODT, Daytrana, Dexedrine Spansules, Dyanavel XR, Focalin XR, Metadate CD, Methylphenidate 72 mg extended-release tablets (branded product), Mydayis, QuilliChew ER, Quillivant XR, Ritalin LA, Ritalin SR, Vyvanse capsules and chewable tablets

**Criteria**

Exceptions for a Step 2 agent can be made for patients with one of the following conditions/situations:

1. If the patient has tried a Step 1 agent, then authorization for a Step 2 agent may be given.

2. Authorization may be given for Daytrana if the patient cannot swallow or has difficulty swallowing solid oral dosage forms.

3. Authorization may be given for Vyvanse for the treatment of binge eating disorder. Vyvanse is the only stimulant indicated for this disorder.11

4. No other exceptions are recommended.

**When Policy Topic is not covered**
The use of ADHD stimulant medications is considered investigational for all other indications.

**Considerations**
ADHD stimulant medications require prior authorization through the Clinical Pharmacy Department.

This Blue Cross and Blue Shield of Kansas City policy statement was developed using available resources such as, but not limited to: Food and Drug Administration (FDA) approvals, Facts and Comparisons, National specialty guidelines, Local medical policies of other health plans, Medicare (CMS), Local providers.

**Description of Procedure or Service**
All of the long-acting stimulants are indicated for the treatment of attention-deficit hyperactivity disorder (ADHD).1-16 Some products are also indicated for the treatment of narcolepsy. Vyvanse is the only stimulant medication indicated for the treatment of binge eating disorder (BED).11 Approval for this indication was based on two 12-week randomized, double-blind, multi-center, parallel-group, placebo-controlled, dose-optimization studies in adults aged 18 to 55 years (n = 374 and n = 350) with moderate to severe BED. Patients from both studies on Vyvanse had a statistically significantly greater reduction from baseline in mean number of binge days/week at Week 12. All of these products have abuse potential and are Schedule II controlled substances.

**Table 1. FDA-Approved Indications for Long-Acting Stimulants.1-16**

<table>
<thead>
<tr>
<th>Product</th>
<th>FDA-Approved Indication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adderall XR® (generics)</td>
<td>ADHD in children 6 to 12 years, adolescents 13 to 17 years, and adults</td>
</tr>
<tr>
<td>Adzenys XR-ODT™</td>
<td>ADHD in patients &gt; 6 years old</td>
</tr>
<tr>
<td>Aptensio XR™</td>
<td>ADHD in patients &gt; 6 years old</td>
</tr>
</tbody>
</table>

**Table 1 (continued). FDA-Approved Indications for Long-Acting Stimulants.1-16**

<table>
<thead>
<tr>
<th>Product</th>
<th>FDA-Approved Indication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerta® (generics)</td>
<td>ADHD in children ≥ 6 years, adolescents (13 to 17 years), and adults ≤ 65 years</td>
</tr>
<tr>
<td>Daytrana®</td>
<td>ADHD in children 6 to 12 years, and adolescents (13 to 17 years)</td>
</tr>
<tr>
<td>Medicine</td>
<td>Indications</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dexedrine® Spansule® (generics)</td>
<td>ADHD in children ≥ 6 years &amp; adolescents up to 16 years</td>
</tr>
<tr>
<td></td>
<td>- Narcolepsy</td>
</tr>
<tr>
<td>Dyanavel™ XR</td>
<td>ADHD in children ≥ 6 years &amp; adults</td>
</tr>
<tr>
<td>Focalin® XR (generics)</td>
<td>ADHD in patients ≥ 6 years</td>
</tr>
<tr>
<td>Metadate® CD (generics)</td>
<td>ADHD in children 6 to 15 years</td>
</tr>
<tr>
<td>Metadate® ER (generics, brand</td>
<td>ADHD in children ≥ 6 years &amp; adults</td>
</tr>
<tr>
<td>product considered generic per</td>
<td>- Narcolepsy</td>
</tr>
<tr>
<td>FDB</td>
<td></td>
</tr>
<tr>
<td>Methylin™ ER (generics, brand</td>
<td>ADHD in children ≥ 6 years &amp; adults</td>
</tr>
<tr>
<td>discontinued)</td>
<td>- Narcolepsy</td>
</tr>
<tr>
<td>QuilliChew ER™</td>
<td>ADHD in children ≥ 6 years &amp; adults</td>
</tr>
<tr>
<td>Quillivant™ XR</td>
<td>ADHD in patients ≥ 6 years</td>
</tr>
<tr>
<td>Ritalin® LA (generics)</td>
<td>ADHD in children 6 to 12 years</td>
</tr>
<tr>
<td>Ritalin-SR® (generics)</td>
<td>ADHD in children ≥ 6 years &amp; adults</td>
</tr>
<tr>
<td></td>
<td>- Narcolepsy</td>
</tr>
<tr>
<td>Vyvanse®</td>
<td>ADHD in children 6 to 12 years, adolescents (13 to 17 years), and adults</td>
</tr>
<tr>
<td></td>
<td>- Bing eating disorder in adults</td>
</tr>
</tbody>
</table>

FDA – Food and Drug Administration; ADHD – Attention-deficit hyperactivity disorder; FDB – First Data Bank.

**Rationale**

The American Academy of Pediatrics (AAP) clinical practice guideline for the diagnosis, evaluation, and treatment of ADHD in children and adolescents\(^\text{17-18}\) was updated in 2011, and incorporates many of the findings from the Multimodal Treatment Study of Children With ADHD (MTA).\(^\text{19}\) Previous AAP guidelines addressed children 6 to 12 years of age. However, there is now emerging evidence to expand the age range of the recommendations to include preschool-aged children and adolescents. The AAP recommendations for treatment of children and youth with ADHD vary depending on the patient's age. For preschool-aged children (4 to 5 years of age), parent- and/or teacher-administered behavior therapy should be prescribed as first-line treatment; methylphenidate may be prescribed if behavior interventions do not provide significant improvement and disturbance of function continues. For elementary school-aged children (6 to 11 years of age), a Food and Drug Administration (FDA)-approved medication for ADHD (and/or behavior therapy, but preferably both) should be prescribed. Evidence is particularly strong for stimulant medications, and sufficient but less strong for Strattera® (atomoxetine capsules), Intuniv® (guanfacine extended-release [ER] tablets), and Kapvay® (clonidine ER tablets) [in that order]. For adolescents (12 to 18 years of age), an FDA-approved medication for ADHD (and behavior therapy, but preferably both) should be prescribed with the assent of the adolescent. The dose of medication should be titrated to achieve maximum benefit with minimum adverse events (AEs). The findings from the MTA study suggested that more than 70% of children and youth with ADHD respond to one of the stimulant medications at an optimal dose when a systematic trial is used. Titration to maximum doses that control symptoms without AEs is recommended instead of titration strictly on a mg-per-kg basis.

Methylphenidate and amphetamine formulations have similar effects and AEs, and remain the first choice of medication treatment.\(^\text{17-18}\) Some patients will respond better to or display more AEs with one compound vs. another; however, these effects cannot be predetermined. Therefore, if a trial with one group is unsuccessful (poor efficacy or AEs), a trial on a medication from the other group should be undertaken. At least half of the patients whose symptoms fail to respond to one stimulant medication may have a positive response to the alternative medication.

The American Academy of Child and Adolescent Psychiatry (AACAP) has also developed a practice parameter for the assessment and treatment of children and adolescents with ADHD.\(^\text{20}\) Like the AAP
practice guideline, it incorporates many of the findings from the MTA. The AACAP guidelines are similar to the AAP guidelines, and recommend stimulants as first-line treatment of ADHD, particularly when no comorbidity is present. The data comparing methylphenidate and amphetamines does not indicate that one class is better than the other.

The American Psychiatric Association (APA) guideline on the treatment of patients with eating disorders (2006 with a Guideline Watch in 2012) does not mention the use of stimulants for the treatment of BED. The guideline suggests treatment with antidepressant medications, particularly SSRI antidepressants, is associated with at least a short-term reduction in binge eating behavior but, in most cases, not with substantial weight loss (recommended with substantial clinical confidence); topiramate is effective for binge reduction and weight loss (recommended with moderate clinical confidence); and zonisamide may produce similar effects regarding weight loss (may be recommended on the basis of individual circumstances). The 2012 Guideline Watch referenced a 2011 literature review by a multinational task force on eating disorders which concluded that Grade A evidence supports the use of imipramine (with moderate risk-benefit ratio), sertraline and citalopram/escitalopram (all with good risk-benefit ratios), and topiramate (with moderate risk-benefit ratio), and Grade D evidence for fluvoxamine and fluoxetine (i.e., inconsistent results). The usefulness of acamprosate and lamotrigine in binge-eating disorder have not been established.

**Dosing and Dosage Forms**

The choice of formulation depends on factors such as the efficacy of each agent for a given child/adolescent, the preferred length of coverage time, whether a child can swallow pills or capsules, and expense. The ER formulations may be preferred over immediate-release (IR) formulations because they provide benefits of consistent and sustained coverage with fewer administrations per day. Long-acting formulations usually preclude the need for school-based administration of ADHD medication. Better coverage with fewer administrations leads to greater convenience for the family and, therefore, might also lead to better adherence to the medication management plan. Some patients, particularly adolescents, might require more than 12 hours of coverage to ensure adequate focus and concentration during evening study time and driving; in these cases, a short-acting (IR) preparation might be used in addition to a long-acting (ER) preparation. In cases where function is impaired less at home than at school, medication may not be needed to cover the hours when the child is out of school. Specialty clinics or child psychiatrists may see complicated cases of combined-type ADHD and children with coexisting oppositional defiant disorder or other psychiatric diagnoses. In these children, target behaviors occur during school and after school. A short-acting medication given three times a day (TID) or a preparation that provides 12-hour coverage may be required to manage their symptoms. The patient’s response to therapy should be monitored in various settings and at different times of the day. The pharmacokinetic properties of the drug being used should be considered since different formulations have different times for peak effect and duration of action. For medications with a relatively short duration of action, multiple doses may need to be given during the day. Dosing during the school day or during after-school activities may be a cause for noncompliance and may raise issues of privacy and storage of the medication at school, as well as ridicule from peers.

Many of the generic ER stimulant medications for the treatment of ADHD are available as capsules: generic amphetamine/dextroamphetamine extended-release capsules (generics to Adderall XR), generic dexamphetamine extended-release capsules (generics to Focalin XR), and generic methylphenidate extended-release capsules (generics to Metadate CD and Ritalin LA). According to the prescribing information, the capsules may be taken whole, or the capsule may be opened and the entire contents sprinkled on applesauce. Patients should take the applesauce with sprinkled beads in its entirety without chewing.

According to the AACAP practice parameter, titration upward every 1 to 3 weeks is recommended until the maximum dose for the stimulant is reached, symptoms of ADHD remit, or side effects prevent further titration, whichever occurs first. The dose of stimulant should be titrated more conservatively in preschoolers than in school-age patients (due to higher rate of emotional adverse events, including crabbiness, irritability, and proneness to crying), and lower mean doses may be effective. This may be
explained by a pharmacokinetic study that determined preschoolers metabolize methylphenidate more slowly than school-age children. Most patients require dose adjustment upward as treatment progresses.

Long-acting formulations of stimulants are equally efficacious as the immediate-release forms and have been shown to be efficacious in adolescents as well as children.

References


**Billing Coding/Physician Documentation Information**

| N/A | The ADHD stimulant medications are considered a pharmacy benefit. |

**Additional Policy Key Words**

Policy Number: 5.01.592

**Policy Implementation/Update Information**

- **07/2014** New Policy titled ADHD Stimulant Step Therapy Program
- **07/2015** Annual Review-no changes made
- **07/2016** Annual Review-no changes made to policy statement; updated list of products and references
- **07/2017** Annual Review-no changes made
- **07/2018** Annual review – no changes made
- **07/2019** Annual review – no changes made

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.