

## Clinical Policy: Preferred Stimulants for Adults with ADHD

Reference Number: WA.PHAR.132

[Coding Implications](#)

Effective Date: 04/2023

Last Review Date: 07/2023

[Revision Log](#)

Line of Business: Medicaid

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

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### Description

To outline criteria for preferred stimulants for Adults with ADHD defined by the Washington State Health Care Authority (HCA)

### Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc. and the Washington State Health Care Authority (HCA) that members 18 years of age and older have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) to receive coverage of a stimulant medications at the pharmacy point-of-sale without prior authorization. An ADHD ICD-10 diagnosis code must be submitted by the pharmacy on the incoming prescription claim or must be found in the member's medical claim history during the past 12 months. Quantity limits and non-clinical type prior authorization requirements still apply.

**A. Attention-Deficit Hyperactivity Disorder: Approval Criteria (must meet all):**

1. Diagnosis of ADHD
2. Request is for a preferred medication
3. Dose does not exceed quantity limits

**Approval Duration:** 12 months or duration of request, whichever is less.

**B. Other Diagnosis/indications (must meet 1 or 2)**

1. If being used for another labeled indication or if this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary, refer to the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary, refer to the non-formulary policy for the relevant line of business: WA.PHAR.61 for Medicaid; or
2. If the requested use is a non-FDA approved indication (e.g. diagnosis, age, dosing regimen) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are

included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

ICD-10-CM Code	Description
F90	Attention-deficit hyperactivity disorders
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F90.8	Attention-deficit hyperactivity disorder, other type
F90.9	Attention-deficit hyperactivity disorder, unspecified type

Reviews, Revisions, and Approvals	Date	Approval Date
New Policy Created	04/12/2023	04/18/2023
Updated numbering in policy	06/06/2023	

**References**

1. N/A

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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