Effective Date :04/01/2022
Reviewed: 01/2022 Scope: Medicaid

Azstarys (serdexmethylphenidate/dexmethylphenidate)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 12 months may be granted when all the following criteria are met:

A. Patient is 6 years or older; AND
B. Patient has documented diagnosis of Attention Deficit Hyperactivity Disorder (ADHD); AND
C. The diagnosis has been appropriately documented (e.g., evaluated by a complete clinical assessment, using DSM-5, standardized rating scales, interviews/questionnaires); AND
D. The patient has experienced a failure, contraindication or intolerance to two generic stimulants and at least one has to be long acting (e.g., amphetamine, amphetamine mixture, dextroamphetamine, methamphetamine, methylphenidate or dexmethylphenidate).

II. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for all members who are tolerating treatment and have documentation of a positive clinical response.

III. QUANTITY LIMIT

- Azstarys 26.1/5.2mg, 39.2/7.8mg, 52.3/10.4mg capsules: one a day

IV. COVERAGE DURATION

- 12 months

.