

January 5, 2011

Montana Health Care Programs Notice

Psychiatrist, Physician, Mid-Level Practitioner, Pharmacy, and Community Mental Health Center

Prior Authorization for Kapvay®

Effective immediately, prior authorization will be required for the following medication:

Kapvay® (clonidine hydrochloride) extended-release tablets have been approved by the Food and Drug Administration (FDA) for the treatment of adolescents ages 6–17 who meet DSM-IV® criteria for attention deficit hyperactivity disorder (ADHD). The following criteria must be met to allow payment for Kapvay®:

- Criteria

- Patient must be between 6 years and 17 years of age.
- Patient must have a diagnosis of attention deficit hyperactivity disorder (ADHD).
- Patient must successfully establish appropriate dose using immediate-release clonidine hydrochloride and have significant compliance issues or inadequate response necessitating the extended-release product.

- Limitations

- Coverage will be limited to twice-daily dosing.
- Maximum dose authorized will be 0.4 mg/day.
- Dose optimization will apply.

The prescriber (physician) or pharmacy may submit requests by mail, telephone, or fax to:

Drug Prior Authorization Unit
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602
(406) 443-6002 or 1-800-395-7961 (Phone)
(406) 443-7014 or 1-800-294-1350 (Fax)

To request prior authorization, providers must submit a *Request for Drug Prior Authorization* form to the Drug Prior Authorization Unit. This form is on the Provider Information [website](#).

Contact Information

If you have questions regarding this notice, please call Amy Holodnick at (406) 444-2738 or the Medicaid Drug Prior Authorization Unit at (406) 443-6002.

For claims questions or additional information, contact Provider Relations:

1-800-624-3958 (Toll-free in- and out-of-state)

(406) 442-1837 (Helena)

E-mail: MTPRHelpdesk@ACS-inc.com

Visit the Provider Information website:

<http://medicaidprovider.hhs.mt.gov/>