Updated: 08/2021
DMMA Approved: 09/2021

Request for Prior Authorization for Vyvanse to treat Binge Eating Disorder
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Vyvanse for Binge Eating Disorder require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Vyvanse for Binge Eating Disorder Prior Authorization Criteria:

For all requests for Vyvanse all of the following criteria must be met:

- Member must be 18 years of age or older.
- Medication must be prescribed by, or in consultation with a psychiatrist or psychiatric nurse practitioner.
- Member must meet DSM-V criteria for Binge Eating Disorder (BED) including ALL of the following:
    - Recurrent episodes of binge eating characterized by BOTH eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances; AND a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
    - The binge eating episodes are associated with THREE or MORE of the following:
        - Eating much more rapidly than normal.
        - Eating until feeling uncomfortable full
        - Eating large amounts of food when not feeling physically hungry
        - Eating alone because of feeling embarrassed by how much one is eating
        - Feeling disgusted with oneself, depressed, or very guilty afterwards.
    - Marked distress regarding binge eating is present
    - Absence of compensatory behaviors such as purging or excessive exercise.
- BED is classified as moderate to severe (moderate: 4-7 binge eating episodes per week; severe: 8-13 binge eating episodes per week) with the number of binge episodes per week documented.
- The prescribed medication is not being used for weight loss or to treat obesity.
- The prescriber confirms that the member's Prescription Monitoring Program (PMP) profile has been reviewed
- Member is not receiving concurrent treatment with a CNS depressant (benzodiazepine or a non-benzodiazepine sedative hypnotic medication). If a member is receiving concurrent treatment with a CNS depressant, a transition plan must be submitted with this request showing removal of concurrent CNS depressant therapy
- Member has been counseled on the potential adverse effects of stimulants, including the risk of serious cardiovascular and psychiatric side effects as well as misuse, abuse, and dependence.

- There must be documentation that non-pharmacologic therapies (such as cognitive-behavioral therapy and/or interpersonal therapy with a clinician) have been utilized within the past 6 months.
- Attestation the member will continue cognitive behavioral therapy or interpersonal therapy with a clinician while on pharmacologic agents.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 4 months
- **Reauthorization Criteria**
    - Attestation from the prescriber that the member's PMP profile has been reviewed
    - Member is not receiving concurrent treatment with a CNS depressant (a benzodiazepine or a non-benzodiazepine sedative hypnotic medication). If a member is receiving concurrent treatment with a CNS depressant, a transition plan must be submitted with this request showing removal of concurrent CNS depressant therapy. Requests for members that are maintaining continued concurrent CNS depressant therapy and not transitioning off will be denied
    - There must be documentation submitted that shows an improvement from baseline in the number of binge days per week.
    - The member continues to receive cognitive behavioral therapy or interpersonal therapy with a clinician while on pharmacologic agents.
    - The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

  Reauthorization Duration of Approval: 6 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

Updated: 08/2021
DMMA Approved: 09/2021

VYVANSE FOR BINGE EATING DISORDER
PRIOR AUTHORIZATION FORM – PAGE 1 of 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Is the member experiencing recurrent episodes of binge eating characterized by:

1. Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances? ☐ Yes ☐ No
2. A sense of lack of control over eating during the episode (ie. a feeling that one cannot stop eating or control what or how much one is eating)? ☐ Yes ☐ No

Is there marked distress regarding binge eating? ☐ Yes ☐ No
Are there any compensatory behaviors such as purging or excessive exercise? ☐ Yes ☐ No
How many binge eating episodes occur per week? ☐ 0 to 3 ☐ 4 to 7 ☐ 8 or more
Which of the following apply to the binge eating episodes:

- ☐ Eating much more rapidly than normal
- ☐ Eating until feeling uncomfortably full
- ☐ Eating large amounts of food when not feeling physically hungry
- ☐ Eating alone because of feeling embarrassed by how much one is eating
- ☐ Feeling disgusted with oneself, depressed, or very guilty afterwards

Is this medication being used for weight loss or to treat obesity? ☐ Yes ☐ No
Has the PMP profile been reviewed? ☐ Yes ☐ No

Updated: 08/2021
DMMA Approved: 09/2021

Is the member receiving concurrent treatment with a CNS depressant (benzodiazepine or sedative hypnotic medication? ☐ Yes *(must provide transition plan for removal of concurrent CNS depressant)* ☐ No
Has the member been counseled on the potential adverse effects of stimulants, including the risk of serious cardiovascular and psychiatric side effects as well as misuse, abuse, and dependence? ☐ Yes ☐ No
Have non-pharmacologic therapies (e.g. cognitive behavioral therapy, interpersonal therapy) been utilized in the past 6 months? ☐ Yes ☐ No
Will the member continue cognitive behavioral therapy or interpersonal therapy with a clinician while on pharmacologic agents? ☐ Yes ☐ No

VYVANSE FOR BINGE EATING DISORDER
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8 am to 7 pm

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REAUTHORIZATION

Has the PMP profile been reviewed? ☐ Yes ☐ No
Is the member receiving concurrent treatment with a CNS depressant (benzodiazepine or sedative hypnotic medication? ☐ Yes *(must provide transition plan for removal of concurrent CNS depressant)* ☐ No
Is the member receiving cognitive behavioral therapy or interpersonal therapy with a clinician while on pharmacologic agents? ☐ Yes ☐ No
Has there been a decrease since baseline in the number of binge eating episodes per week? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date