Updated: 10/2019
DMMA Approved: 10/2019

Request for Prior Authorization for Vyvanse (Lisdexamfetamine)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Vyvanse (Lisdexamfetamine) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Vyvanse (Lisdexamfetamine) 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 prescriber has checked the PMP profile for the member and confirmed the member is not concurrently on benzodiazepines or stimulants.
- Member must not be taking or has not taken monoamine oxidase inhibitors (MAOIs) in the past 14 days.
- The member does not have cardiac disease (coronary artery disease, serious heart arrhythmias, structural cardiac abnormalities, cardiomyopathy).
- The prescribed medication is not being used for weight loss or to treat obesity.
- Member must not have a history of substance abuse.
- 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:** 16 weeks
- **Reauthorization Criteria**
    - 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, for prescriber to observe continued improvement

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.

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VYVANASE FOR BINGE EATING DISORDER
PRIOR AUTHORIZATION FORM

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) 325-6253 Monday through Friday 8:30am to 5:00pm

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: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
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 (if medically please provide a 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-10 code:_____

Does the member have **both** characteristics of recurrent episodes of binge eating: eating in a discrete period of time an amount of food definitely larger than most would eat in a similar period of time and a sense of lack of control over eating during the episode? ☐ Yes ☐ No

Do the binge eating episodes have **three (3) or more** of the following (check all that apply)?

☐ Eating until uncomfortably full ☐ Eating more rapidly than normal
☐ Eating large amounts when not physically hungry
☐ Eating alone out of embarrassment ☐ Feeling disgusted, depressed, or guilty after eating

Is there marked distress regarding binge eating? ☐ Yes ☐ No
Does the member binge eat on average at least once per week for 3 months? ☐ Yes ☐ No
Is there the absence of compensatory behaviors, such as purging or excessive exercise? ☐ Yes ☐ No

Is the members BED classified as moderate to severe? ☐ Yes ☐ No
Baseline number of binge eating episodes per week:_____

Is the member taking or has taken in the past 14 days a monoamine oxidase inhibitor? ☐ Yes ☐ No
Does the member have a history of cardiovascular disease or has developed cardiac disease while on therapy?
☐ Yes, diagnosis_____ ☐ No

Does the member have a history of substance abuse? ☐ Yes ☐ 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
Has the PMP profile has been checked for this member? ☐ Yes ☐ No
If Yes, is the member taking any opioids, benzodiazepines, or stimulants? ☐ Yes ☐ No

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

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PHONE: (844) 325-6253 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Current number of binge eating episodes per week while on treatment: _____

Is the member continuing to receive non-pharmacologic therapy while on Vyvanse? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date