USFHP Prior Authorization Request Form for

Lisdexamfetamine capsule and chewable tablet (**Vyvanse**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. For which diagnosis is the requested medication being prescribed?	☐ Attention Deficit Hyperactivity Disorder (ADHD) - **Proceed to question 2** ☐ Moderate to severe Binge Eating Disorder- **Proceed to question 5** ☐ Weight loss/Obesity - **STOP- Coverage not approved** ☐ Other indication or diagnosis- **STOP- Coverage not approved**	
2. Is the patient 6 years of age or older?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Has the patient tried and failed mixed amphetamine salts ER (Adderall XR, generics) or another long acting amphetamine or amphetamine derivative type drug?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed methylphenidate OROS (Concerta, generics) or another long acting methylphenidate or methylphenidate derivative type drug?	☐ Yes **Proceed to question 13**	☐ No **STOP** **Coverage not approved**
5. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 6**	☐ No **Proceed to question 7**
6. Provider acknowledges the need to consult service specific policy for Binge Eating Disorder (BED).	☐ Acknowledged **Proceed to question 7**	
7. Is the patient 18 years of age or older?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**

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8. Was the requested medication prescribed by or in consultation with a psychiatrist or other behavioral specialist?	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
9. Has the patient failed, does not have access to, or had an inadequate response to cognitive behavioral therapy or other psychotherapy?	☐ Yes **Proceed to question 10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and failed OR had a contraindication to an SSRI (for example, citalopram, fluoxetine, sertraline)?	☐ Yes **Proceed to question 11**	☐ No **STOP** **Coverage not approved**
11. Has the patient tried and failed OR had a contraindication to topiramate or zonisamide?	☐ Yes **Proceed to question 12**	☐ No **STOP** **Coverage not approved**
12. Provider acknowledges Vyvanse will be discontinued if the patient does not respond by having a positive clinical response, defined as a meaningful decrease of binge eating episodes or binge days per week from baseline, or improvement in signs and symptoms of binge eating disorder after taking Vyvanse.	☐Acknowledged **Proceed to question 13**	
13. What is the requested medication?	☐ Vyvanse or lisdexamfetamine capsules – **Sign and date below** ☐ Vyvanse or lisdexamfetamine chewable tablets – **Proceed to question 14**	
14. Provider acknowledges that brand Vyvanse formulation is the preferred product over generic lisdexamfetamine chewable tablet and is covered at the lowest copayment, which is the generic formulary copayment for non-Active-Duty patients, and at no cost share for Active-Duty patients. (Although Vyvanse is a branded product, it will be covered at the generic formulary copayment or cost share).	☐Acknowledged **Proceed to question 15**	
15. What is the requested medication?	☐ brand Vyvanse **Sign and date below**	☐ other **Proceed to question 16**
16. Please provide a patient-specific justification as to why the brand Vyvanse cannot be used in this patient.	_____ **Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date