## 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.    Please complete patient and physician information (please print):   Patient Name:							
Physician Name: Address: Address: Address: Address: Address:  Phone #: Date of Birth:  Secure Fax #:    Phone #:	Prio	r authorization does not expire.					
Address:    Sponsor ID #	Step	Please complete patient and physician information (please print):					
Address:  Sponsor ID # Date of Birth:  Secure Fax #:  Step 2  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   Other indication or diagnosis-STOP- Coverage not approved   Yes Proceed to question 3   No STOP Coverage not approved   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?  4. Has the patient tried and failed methylphenidate OROS (Concerta, generics) or another long acting methylphenidate or methylphenidate derivative type drug?  5. Is the patient an Active Duty Service Member (ADSM)?   Yes   No Proceed to question 6   No Proceed to question 7   No Proceed to question 7   Acknowledged the need to consult service specific policy for Binge Eating Disorder (BED). Please type   No Proceed to question 7   No Proceed to question 8   No STOP   No Proceed to question 8   No STOP   No Proceed to question 7   No Proceed to question 7   No Proceed to question 8   No STOP   No STOP	1	Patient Name: Physician Name:					
Date of Birth:   Secure Fax #:		·					
Date of Birth:   Secure Fax #:							
Please complete the clinical assessment:    1. For which diagnosis is the requested medication being prescribed?		· -					
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   Other indication or diagnosis- STOP- Coverage not approved   STOP   Yes   No STOP   Yes   No STOP   No STOP   No STOP   STOP   No S		Date of Birth:	Secur	e Fax #:			
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   Other indication or diagnosis- STOP- Coverage not approved   Yes	•	Please complete the clinical assessmen	se complete the clinical assessment:				
Weight loss/Obesity - STOP- Coverage not approved   Other indication or diagnosis- STOP- Coverage not approved   Other indication or diagnosis- STOP- Coverage not approved   No STOP   STOP   Coverage not approved   No STOP   No STOP   Coverage not approved   No STOP   No			☐ Attention Deficit Hyperactivity Disorder (ADHD) - Proceed to question 2				
Other indication or diagnosis- STOP- Coverage not approved  2. Is the patient 6 years of age or older?    Yes   No STOP		medication being prescribed?	,				
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methylphenidate derivative type drug?  5. Is the patient an Active Duty Service Member (ADSM)?    Yes   No     Proceed to question 6     Proceed to question 7     Acknowledged type     Proceed to question 7     The patient 18 years of age or older?     Yes   No     Proceed to question 6     Proceed to question 7     Acknowledged     Proceed to question 7     Yes   No     Proceed to question 8     No     Proceed to question 8     No     STOP		(Concerta, generics) or another long acting methylphenidate or		□ Yes	□ No		
5. Is the patient an Active Duty Service Member (ADSM)?    Yes   No				Proceed to question 13	STOP		
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service specific policy for Binge Eating Disorder (BED). Please type  7. Is the patient 18 years of age or older?  Proceed to question 8  Proceed to question 8  STOP				Proceed to question 6	Proceed to question 7		
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Proceed to question 8 STOP							
STOP		7. Is the patient 18 years of age or older?					
					STOP Coverage not approved		

## USFHP Prior Authorization Request Form for Lisdexamfetamine capsule and chewable tablet (**Vyvanse**)

	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	☐ Yes Proceed to question 10	□ No STOP	
	psychotherapy?		Coverage not approved	
	10. Has the patient tried and failed OR had a contraindication to an	☐ Yes	□ No	
	SSRI (for example, citalopram, fluoxetine, sertraline)?	Proceed to question 11	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	
	topiramate of Zemeamae.	<b>,</b>	Coverage not approved	
	12. Note to provider: 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.		nowledged o question 13	
	13. What is the requested medication?	☐ Vyvanse capsules – <b>Sig</b>	Vyvanse capsules – Sign and date below	
	· 	☐ Vyvanse chewable tablets – Proceed to question 14		
	14. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did	□ Yes	□ No	
	not previously have a TRICARE approved PA for Vyvanse.	(subject to verification)	proceed to question 15	
		Sign and date below		
	15. The brand Vyvanse formulation is the preferred product over generic lisdexamfetamine 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)			
	Please type "Acknowledge" and proceed to the next question.	Proceed to question 16		
	16. What is the requested medication?	□ brand Vyvanse Sign and date below	□ other  Proceed to question 17	
	17. 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. F	Please sign and date:		
	Prescriber Signature	Date		
			[08 Sontombor 2025]	

[08 September 2025]