

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.

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 (ADSM)?	☐ Yes Proceed to question 6	☐ No Proceed to question 7
6. Note to provider: please acknowledge the need to consult service specific policy for Binge Eating Disorder (BED). Please type	☐ 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. 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.	☐ Acknowledged Proceed to question 13	
13. What is the requested medication?	☐ 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? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for Vyvanse.</i>	☐ Yes (subject to verification) Sign and date below	☐ No proceed to question 15
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. Please sign and date:

Prescriber Signature

Date