OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: Vyvanse® (lisdexamfetamine) for ***BINGE EATING DISORDER (BED)***

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable*: _____**

Recommended dose is 30 mg/day. Maximum dose is 70mg/day.

CLINICAL CRITERIA: Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed. Chart notes (documentation) MUST be attached to request.

Initial Authorization (6 month time period)

Patient eats in a set amount of time an amount of food that is definitely larger than what most people would eat in that same amount of time.	❑ Yes	❑ No
Patient has a sense of lack of control over eating.	❑ Yes	❑ No
Patient's binge eating episodes are associated with *3 OR MORE* of the following: ❑ 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 embarrassment over how much one is eating ❑ Feeling disgusted, guilty, or depressed afterward	❑ Yes	❑ No
Patient has marked distress regarding the presence of binge eating	❑ Yes	❑ No
Patient's binge eating occurs, on average, at least once a week for 3 months	❑ Yes	❑ No
Patient's binge eating is associated with the use of inappropriate compensatory mechanisms	❑ Yes	❑ No
Patient is diagnosed with bulimia nervosa or anorexia nervosa	❑ Yes	❑ No
Please provide member's height, weight, and BMI:	Ht: _____ Wt:_____ BMI:_____	
Please provide the number of binge eating days/week that member experiences:	# of Binge Eating Days/Week: _____	
Patient is currently receiving psychotherapy from a behavioral health clinician	❑ Yes	❑ No
****CHART NOTES DOCUMENTING THAT THE MEMBER MEETS *ALL* DSM CRITERIA AND IS RECEIVING PSYCHOTHERAPY *MUST* BE SUBMITTED FOR APPROVAL****	❑ Chart Notes Attached	

(continued on next page)

Continued Approval

based on submission of Progress notes documenting improvement (decrease in Binge Eating days/week and weight)

❑ **Date**: _____	❑ **# of Binge Eating Days/Week**: _____	❑ **Weight**: _____	❑ **Progress Notes Attached**

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 7/1/2018**