OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 or authorization process will be delayed.

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 to ensure authorization will **NOT** 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:_____	

(continued on next page)

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 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:** ~~8/27/2017;~~ **9/1/2018**;