

# OPTIMA HEALTH COMMUNITY CARE

## 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 1-800-319-5003. 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient has a sense of lack of control over eating.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Patient's binge eating episodes are associated with <u>3 OR MORE</u> of the following:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Eating much more rapidly than normal</li> <li><input type="checkbox"/> Eating until feeling uncomfortably full</li> <li><input type="checkbox"/> Eating large amounts of food when not feeling physically hungry</li> <li><input type="checkbox"/> Eating alone because of embarrassment over how much one is eating</li> <li><input type="checkbox"/> Feeling disgusted, guilty, or depressed afterward</li> </ul>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient has marked distress regarding the presence of binge eating	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient's binge eating occurs, on average, at least once a week for 3 months	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient's binge eating is associated with the use of inappropriate compensatory mechanisms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient is diagnosed with bulimia nervosa or anorexia nervosa	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>**CHART NOTES DOCUMENTING THAT THE MEMBER MEETS <u>ALL DSM CRITERIA</u> AND IS <u>RECEIVING PSYCHOTHERAPY</u> <u>MUST</u> BE SUBMITTED FOR APPROVAL**</b>	<input type="checkbox"/> 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)*

<input type="checkbox"/> <b>Date:</b> _____	<input type="checkbox"/> <b># of Binge Eating Days/Week:</b> _____	<input type="checkbox"/> <b>Weight:</b> _____	<input type="checkbox"/> <b>Progress Notes Attached</b>
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**\*\*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