**OPTIMA HEALTH PLAN**

**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; (Pharmacy) 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

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

**DRUG INFORMATION:** Complete information below or authorization 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. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

<table>
<thead>
<tr>
<th>Clinical Criteria</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>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.</td>
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<td>Patient has a sense of lack of control over eating.</td>
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<td>Patient’s binge eating episodes are associated with <strong>3 OR MORE</strong> of the following:</td>
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<td>Eating much more rapidly than normal</td>
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<td>Eating until feeling uncomfortably full</td>
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<td>Eating large amounts of food when not feeling physically hungry</td>
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<td>Eating alone because of embarrassment over how much one is eating</td>
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<td>Feeling disgusted, guilty, or depressed afterward</td>
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<td>Patient has marked distress regarding the presence of binge eating</td>
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<td>Patient’s binge eating occurs, on average, at least once a week for 3 months</td>
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<td>Patient’s binge eating is associated with the use of inappropriate compensatory mechanisms</td>
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<td>Patient is diagnosed with bulimia nervosa or anorexia nervosa</td>
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*(Continued on next page)*
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**

**Length of Initial Authorization is 6 MONTHS; Continued Approval is based on submission of progress notes documenting improvement (decrease in binge eating Days/Week and weight.)**

**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 #: _______________________________________________________________________

*Approved by Pharmacy and Therapeutics Committee: 4/16/2015
REVISED/UPDATED: 10/9/2015; 12/29/2015; 12/20/2016; 8/20/2017; (Reformatted) 6/18/2019