PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

CNS Stimulants Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
❑ Binge eating disorder (BED) – moderate to severe [**Vyvanse** only]
❑ Other diagnosis:_____ICD-10 Code(s): _____
❑ Obesity [**Desoxyn (methamphetamine) & Evekeo** only]
❑ Narcolepsy (confirmed by sleep study)
❑ Depression (for augmentation of antidepressant therapy)

ADD or ADHD:

Have symptoms been present prior to 12 years of age? ❑ **Yes** ❑ **No**
Does the patient have symptoms which interfere with or reduce the quality of academic or occupational functioning? ❑ **Yes** ❑ **No**
Was the prescription for the requested medication written by or in consultation with a mental health specialist? ❑ **Yes** ❑ **No**

Binge eating disorder (BED) – moderate to severe [**Vyvanse** only]:

Has the patient had binge eating disorder for 3 months or longer? ❑ **Yes** ❑ **No**
Does the patient have between 4 and 13 binge-eating episodes per week? ❑ **Yes** ❑ **No**
Does the patient eat much more rapidly than normal? ❑ **Yes** ❑ **No**
Does the patient eat until feeling uncomfortably full? ❑ **Yes** ❑ **No**
Does the patient eat large amounts of food when not feeling physically hungry? ❑ **Yes** ❑ **No**
Does the patient eat alone because of feeling embarrassed by how much he or she is eating? ❑ **Yes** ❑ **No**
Does the patient feel disgusted with himself or herself, depressed, or very guilty after binge-eating? ❑ **Yes** ❑ **No**

Reauthorization [**Vyvanse** only]:
If this is a reauthorization request, answer the following:
Is there documentation of positive clinical response (e.g., meaningful reduction in the number of binge eating episodes or binge days per week from baseline, improvement in the signs and symptoms of binge eating disorder) to Vyvanse therapy? ❑ **Yes** ❑ **No**

Narcolepsy:

Has a sleep study confirming the diagnosis of narcolepsy been performed and the results submitted with this form? ❑ **Yes** ❑ **No**
If there is a reason that a sleep study would not be feasible, please explain in the comments section below.

Obesity [**Desoxyn (methamphetamine) & Evekeo** only]**:**

Is the requested medication used for short term (i.e., a few weeks) adjunct therapy for exogenous obesity? ❑ **Yes** ❑ **No**
Is the patient refractory to alternative therapy (e.g., repeated diets, group programs, medications)? ❑ **Yes** ❑ **No**
Does the patient have a body mass index (BMI) greater than or equal to 30kg/m^2? ❑ **Yes** ❑ **No**
Does the patient have a BMI greater than or equal to 27kg/m^2? ❑ **Yes** ❑ **No**
Does the patient have a weight-related comorbidity (e.g., hypercholesterolemia, hypertension, diabetes, sleep apnea)? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Amphetamine-dextroamphetamine
❑ Amphetamine-dextroamphetamine extended-release (ER)
❑ Adderall XR
❑ Dexmethylphenidate
❑ Dexmethylphenidate ER
❑ Dextroamphetamine
❑ Dextroamphetamine ER
❑ Metadate ER
❑ Methamphetamine
❑ Methylphenidate
❑ Methylphenidate ER
❑ Vyvanse
❑ Other CNS stimulant(s). Please specify: _____

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Quantity limit requests:
What is the quantity requested per DAY? _____
Is the prescription written by or in consultation with a mental health specialist? ❑ **Yes** ❑ **No**
Will adequate scientific literature, peer-reviewed medical literature, or national compendia supporting the use of higher doses be provided? ❑ **Yes** ❑ **No**
***Please note: Submission of information requested above is required for quantity limit requests for this drug.*
What is the reason for exceeding the plan limitations?
❑ Titration
❑ Loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	