PRO ACT PHARMACY BENEFIT MANAGEMENT

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

Vyvanse® Prior Authorization Request Form (Page 1 of 2)

Patient Information (required)			Provider Information (required)		
Patient 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
❑ Attention deficit hyperactivity disorder
❑ Binge eating disorder (moderate to severe)
❑ Other diagnosis:_____ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Amphetamine-dextroamphetamine
❑ Amphetamine-dextroamphetamine extended-release (ER)
❑ Dexmethylphenidate
❑ Dexmethylphenidate ER
❑ Dextroamphetamine
❑ Dextroamphetamine ER
❑ Metadate ER
❑ Methylphenidate (generic Ritalin)
❑ Methylphenidate chewable tablet
❑ Methylphenidate controlled-release (CD) (generic Metadate CD)
❑ Methylphenidate ER (10mg, 20mg tablets)
❑ Methylphenidate ER (generic Concerta)
❑ Methylphenidate ER (generic Ritalin LA)
❑ Methylphenidate solution
❑ Quillivant XR

Moderate to severe Binge Eating Disorder:
Has the patient had binge eating disorder for 3 months or longer? ❑ **Yes** ❑ **No**
Has the patient had 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 one is eating? ❑ **Yes** ❑ **No**
Does the patient feel disgusted with oneself, depressed, or very guilty after binge-eating? ❑ **Yes** ❑ **No**
Reauthorization. If this is a reauthorization request, answer the following question:
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 the Vyvanse therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or 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
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
❑ Other: _____

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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:	