AvMed

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 1-305-671-0200**. 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)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: ______________________________

Member AvMed #: ______________________ **Date of Birth:** ____________

Prescriber Name: ______________________________

Prescriber Signature: ______________________ **Date:** ____________

Office Contact Name: ______________________________

Phone Number: ______________________ **Fax Number:** ____________

DEA OR NPI #: ______________________________

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy**: ____________

Diagnosis: ______________________ **ICD Code, if applicable:** ____________

Weight: ______________________ **Date:** ____________

Recommended dose is 30 mg/day. Maximum dose is 70mg/day.

CLINICAL CRITERIA/DIAGNOSIS: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Criteria	Yes	No
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

(Continued on next page)

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: ___________	
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	

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

***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; 10/11/2021;~~ **10/27/2023**