TRICARE Prior Authorization Request Form for

Lisdexamfetamine capsule and chewable tablet (**Vyvanse**)

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. For which diagnosis is the requested medication being prescribed?	☐ Attention Deficit Hyperactivity Disorder (ADHD) - **Proceed to question 2** ☐ Moderate to severe Binge Eating Disorder- **Proceed to question 5** ☐ Weight loss/Obesity - **STOP- Coverage not approved** ☐ Other indication or diagnosis- **STOP- Coverage not approved**	
2. Is the patient 6 years of age or older?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Has the patient tried and failed mixed amphetamine salts ER (Adderall XR, generics) or another long acting amphetamine or amphetamine derivative type drug?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed methylphenidate OROS (Concerta, generics) or another long acting methylphenidate or methylphenidate derivative type drug?	☐ Yes **Proceed to question 13**	☐ No **STOP** **Coverage not approved**
5. Is the patient an Active Duty Service Member (ADSM)?	☐ Yes **Proceed to question 6**	☐ No **Proceed to question 7**
6. Note to provider: please acknowledge the need to consult service specific policy for Binge Eating Disorder (BED). Please type "Acknowledge" and proceed to the next question.	______________________ **Proceed to question 7**	
7. Is the patient 18 years of age or older?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Was the requested medication prescribed by or in consultation with a psychiatrist or other behavioral specialist?	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**

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9. Has the patient failed, does not have access to, or had an inadequate response to cognitive behavioral therapy or other psychotherapy?	☐ Yes **Proceed to question 10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and failed OR had a contraindication to an SSRI (for example, citalopram, fluoxetine, sertraline)?	☐ Yes **Proceed to question 11**	☐ No **STOP** **Coverage not approved**
11. Has the patient tried and failed OR had a contraindication to topiramate or zonisamide?	☐ Yes **Proceed to question 12**	☐ No **STOP** **Coverage not approved**
12. Note to provider: Vyvanse will be discontinued if the patient does not respond by having a positive clinical response, defined as a meaningful decrease of binge eating episodes or binge days per week from baseline, or improvement in signs and symptoms of binge eating disorder after taking Vyvanse. Please type "Acknowledge" and proceed to the next question.	______ **Proceed to question 13**	
13. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Vyvanse.*	☐ **Yes** (subject to verification) **Sign and date below**	☐ **No** **proceed to question 14**
14. The brand Vyvanse formulation is the preferred product over generic lisdexamfetamine and is covered at the lowest copayment, which is the generic formulary copayment for non-Active-Duty patients, and at no cost share for Active-Duty patients. (Although Vyvanse is a branded product, it will be covered at the generic formulary copayment or cost share) Please type "Acknowledge" and proceed to the next question.	______ **Proceed to question 15**	
15. What is the requested medication?	☐ brand Vyvanse **Sign and date below**	☐ other **Proceed to question 16**
16. Please provide a patient-specific justification as to why the brand Vyvanse cannot be used in this patient.	______ **Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________ Prescriber Signature ______________ Date

[08 May 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: