TRICARE Prior Authorization Request Form for
Lisdexamfetamine capsule and chewable tablet (Vyvanse)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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

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 **Sign and date below**	☐ 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).	☐ Acknowledged **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**
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**

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

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: please acknowledge that 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.	☐ Acknowledged **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

[03 Mar 2021]

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