SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-800-750-9692**. 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 Sentara #: _____ **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:** _____

CLINICAL CRITERIA: 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.

Initial Authorization: 6 month time period

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
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

(Continued on next page)

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	

<u>Continued Approval</u> based on submission of Progress notes documenting improvement (decrease in Binge Eating days/week and weight)			
❑ **Date**: _____	❑ **# of Binge Eating Days/Week**: _____	❑ **Weight**: _____	❑ **Progress Notes Attached**

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

****<u>Previous therapies will be verified through pharmacy paid claims or submitted chart notes.</u>****

***REVISED/UPDATED/REFORMATTED:** ~~8/27/2017; 9/1/2018; 1/6/2020;~~ **11/10/2023**