OPTIMA HEALTH PLAN

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 information provided is not complete, correct, or legible, authorization can be delayed.**

Drug Requested: Vyvanse® (lisdexamfetamine) for **BINGE EATING DISORDER (BED)**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

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. Check box below for the Diagnosis that applies.

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
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

(Continued on next page)

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.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***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**;