# SENTARA HEALTH PLANS

## 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. |
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**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. |
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**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. |
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|---|---|---|
| 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 <u>3 OR MORE</u> of the following**: <br> ❑ Eating much more rapidly than normal <br> ❑ Eating until feeling uncomfortably full <br> ❑ Eating large amounts of food when not feeling physically hungry <br> ❑ Eating alone because of embarrassment over how much one is eating <br> ❑ 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: _____ <br> Wt: _____ <br> 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 <u>ALL</u> DSM CRITERIA AND IS <u>RECEIVING PSYCHOTHERAPY</u> <u>MUST</u> 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.\*\**