Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Vyvanse (lisdexamfetamine) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Vyvanse (lisdexamfetamine).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

If treating Attention Deficit Hyperactivity Disorder (ADHD):

1. Does the patient have a diagnosis of ADHD as confirmed by psychoeducational testing****?
   □ No □ Yes

2. Is the patient 6 years of age or older?
   □ No □ Yes

3. Is the medication being prescribed by or in consultation with a Psychiatrist?
   □ No □ Yes

4. Has the patient had an adequate trial* (1 week) and/or intolerance** or allergy to ALL of the following medications?
   - Dextroamphetamine-amphetamine (generic Adderall XR)
   - Intermediate or long-acting methylphenidate (methylphenidate SR, methylphenidate CD, or methylphenidate ER)
   - Dexmethylphenidate (generic Focalin XR)
   - Lisdexamfetamine (generic Vyvanse)

   □ No □ Yes

If treating Binge Eating Disorder:

1. Does the patient have a diagnosis of Binge Eating Disorder (BED)***?
   □ No □ Yes

2. Is the medication being prescribed by or in consultation with a psychiatrist?
   □ No □ Yes

3. Is the patient 18 years of age or older?
   □ No □ Yes

4. Has the patient had prior adequate trial* (6 weeks) and failure of 2 formulary Selective Serotonin Reuptake Inhibitors (SSRIs) unless contraindication, intolerance, or allergy?
   □ No □ Yes

5. Has the patient had prior adequate trial* (1 month) and failure of topiramate or atomoxetine unless contraindication, intolerance, or allergy?
   □ No □ Yes

6. Has the patient had prior adequate trial* (1 week) and/or intolerance** or allergy to lisdexamfetamine (generic Vyvanse)?
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Does the patient continue to meet the initial review criteria, and has the patient demonstrated positive clinical response to medication?
   □ No □ Yes

***NOTES**:*

**Adequate trial of a long-acting agent is further defined as wearing off that is not resolved by increasing the dose, AND adding a short-acting agent OR increasing frequency to twice daily OR clinically significant side effects related to the dosage form that cannot be resolved by adjusting the dose or timing*

***Intolerance excludes adverse drug reactions that are expected, mild in nature, resolve with continued treatment and do not require medication discontinuation*

****Criteria only applies to new start patients*

*****Criteria only applies for 18 years of age and older*

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**