OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Vyvanse® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Patient Information (required)

Patient Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Attention deficit disorder
❑ Attention deficit hyperactivity disorder
❑ Binge eating disorder (moderate to severe)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Amphetamine-dextroamphetamine
❑ Amphetamine-dextroamphetamine extended-release (ER)
❑ Dexmethylphenidate
❑ Dexmethylphenidate ER
❑ Dextroamphetamine
❑ Dextroamphetamine ER
❑ Metadate ER
❑ Methylphenidate (generic Ritalin)
❑ Methylphenidate chewable tablet
❑ Methylphenidate controlled-release (CD) (generic Metadate CD)
❑ Methylphenidate ER (10mg, 20mg tablets)
❑ Methylphenidate ER (18mg, 27mg, 36mg, 54mg, 72mg tablets)
❑ Methylphenidate ER (generic Ritalin LA)
❑ Methylphenidate solution
❑ Procentra
❑ Quillivant XR
❑ Relexxii
❑ Zenzedi

Moderate to severe Binge Eating Disorder:

Has the patient had binge eating disorder for 3 months or longer? ❑ **Yes** ❑ **No**
Has the patient had between 4 and 13 binge-eating episodes per week? ❑ **Yes** ❑ **No**
Does the patient eat much more rapidly than normal? ❑ **Yes** ❑ **No**
Does the patient eat until feeling uncomfortably full? ❑ **Yes** ❑ **No**
Does the patient eat large amounts of food when not feeling physically hungry? ❑ **Yes** ❑ **No**
Does the patient eat alone because of feeling embarrassed by how much he or she is eating? ❑ **Yes** ❑ **No**
Does the patient feel disgusted with himself or herself, depressed, or very guilty after binge-eating? ❑ **Yes** ❑ **No**

Reauthorization. If this is a reauthorization request, answer the following question:

Is there documentation of positive clinical response (e.g., meaningful reduction in the number of binge eating episodes or binge days per week from baseline, improvement in the signs and symptoms of binge eating disorder) to the Vyvanse therapy? ❑ **Yes** ❑ **No**

Vyvanse® Prior Authorization Request Form (Page 2 of 2)

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Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.