Prior Authorization Form

CAREMARK FAX FORM

Vyvanse

This fax machine is located in a secure location as required by HIPAA regulations. Complete information, sign and date. Fax completed forms to Caremark at 1-888-836-0730

Please contact Caremark @ 1-888-414-3125 with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Vyvanse

ı	Drug Name:		
Ī	Patient: Patient Name: Patient ID:		
	Patient Group Numb	er:	
	Patient Date Of Birth		
	Prescribing Physicia	an:	
ı	Physician Name:		
ı	Physician Phone:		
	Physician Fax:		
	Physician Physician City, State	a 7in:	
	nysician only, olan	<u></u>	
	Diagnosis:	ICD 9 code:	Please circle the appropriate answer for each applicable question.
1	Is the patient 3 years of	old or older?	Y
2	Does the patient have	a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD)?	Y
	[If the answer to this q	uestion is yes, skip to question 7.]	
3	Is the medication bein	g prescribed Vyvanse (lisdexamfetamine)?	Y
	[If the answer to this q	uestion is yes, then no further questions required.]	
4	Does the patient have	the diagnosis of narcolepsy?	Y
	[If the answer to this q	uestion is no, then no further questions required.]	·
5	Has the diagnosis been	n confirmed by sleep studies?	Y
6		valuated for other causes of excessive daytime sleepiness (e.g., insufficient airway resistance syndrome, depression)?	Y
	[Skip to question 10.]		
7	Does the patient have home)?	ADHD symptoms in more than one setting (e.g., school/daycare or work,	Y
8	Has the patient had Al	OHD symptoms for longer than 6 months?	Y
9	Are the ADHD symptoccupational functioni	oms causing clinically significant impairment in social, academic, or ng?	YN
10		a monoamine oxidase inhibitor (MAOI) drug while taking this therapy or a an MAOI drug in the previous 14 days?	Y
	[MAOI drugs include: and selegiline (Eldepr	phenelzine (Nardil), tranylcypromine (Parnate), isocarboxazid (Marplan), yl, Emsam).]	
11		ularly monitored for adverse events, including weight loss and decreased ildren, increased heart rate and blood pressure, the appearance or worsening	Y

of aggressive behavior or hostility, sleep disturbances, and long-term usefulness of the drug?

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Drug Name:					
Patient:					
Patient Name: Patient ID:					
Patient Group Number:					
Patient Date Of Birth:					
Comments:					
Information given on this form is accurate as of this date.					

Prescriber or Authorized Signature