Prescriber Criteria Form Vyvanse 2024 PA Fax 3674-A v2 010124.docx Vyvanse (lisdexamfetamine) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Vyvanse (lisdexamfetamine).

Drug Name: Vyvanse (lisdexamfetamine)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? [If no, then skip to question 3.]	Yes	No
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to a generic central nervous system (CNS) stimulant (e.g., amphetamine, dextroamphetamine, methylphenidate)? [No further questions.]	Yes	No
3	Is the requested drug being prescribed for the treatment of moderate to severe binge eating disorder (BED) in an adult?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____