Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Binge Eating Disorder (BED) Agents (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of BED Agents (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
VYVANSE 10MG CAPSULE	VYVANSE 10MG CHEWABLE TABLET	VYVANSE 20MG CAPSULE
VYVANSE 20MG CHEWABLE TABLET	VYVANSE 30MG CAPSULE	VYVANSE 30MG CHEWABLE TABLET
VYVANSE 40MG CAPSULE	VYVANSE 40MG CHEWABLE TABLET	VYVANSE 50MG CAPSULE
VYVANSE 50MG CHEWABLE TABLET	VYVANSE 60MG CAPSULE	VYVANSE 60MG CHEWABLE TABLET
VYVANSE 70MG CAPSULE	OTHER:_____	

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 180 days.
   If the answer to this question is no, go to question 2.

2. Is the patient less than 6 years of age? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 3.

3. Does the patient have a diagnosis of ADD/ADHD in the last 730 days? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, go to question 4.

4. Does the patient have a diagnosis of binge eating disorder (BED) in the last 730 days? Y N
If the answer to this question is yes, go to question 5.
If the answer to this question is no, denied.

5. Is the patient less than 18 years of age? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 6.

6. Does the patient have at least 60 days therapy with an agent for the treatment of BED in the last 180 days? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, denied.

7. Is the request for greater than the Texas Department of Family and Protective Services (DFPS) maximum recommended dose (See Table A)? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 8.

8. Does the patient have a history of substance abuse in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 9.

9. Does the patient have a paid claim for another ER stimulant in the past 14 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 10.

10. Does the patient have a diagnosis of severe cardiac disease in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 11.

11. Does the patient have a claim for a monoamine oxidase (MAO) inhibitor in the last 14 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 12.

12. Does the patient have a diagnosis of severe renal impairment in the last 365 days? Y N
If the answer to this question is yes, go to question 13.
If the answer to this question is no, go to question 14.

13. Is the requested dose less than or equal to 50 mg per day? Y N
If the answer to this question is yes, go to question 16.
If the answer to this question is no, denied.

14. Does the patient have a diagnosis of end stage renal disease (ESRD) in the last 365 days? Y N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, go to question 16.

15. Is the requested dose less than or equal to 30 mg per day? Y N
If the answer to this question is yes, go to question 16.
If the answer to this question is no, denied.

16. Is the request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 17.
If the answer to this question is no, approved for 180 days.

17. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N

If the answer to this question is yes, approved for 180 days.
If the answer to this question is no, go to question 18.

18. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 180 days.
If the answer to this question is no, go to question 19.

19. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 180 days.
If the answer to this question is no, denied.

Table A: TX DFPS Recommended Dosage

Active Ingredient	Drug (brand)	Initial Dosage	Literature Based Maximum Dosage	FDA Approved Maximum Dosage for Children and Adolescents
Lisdexamfetamine	Vyvanse Capsule Vyvanse Chewable	Age ≥ 6 years: 30mg/day	Age ≥ 6 years: 70mg/day	Approved for children 6 years and older: 70mg/day

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____
Prescriber (or Authorized) Signature Date