



**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:**

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

**Prescriber Signature:**

**Date:**

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