Medicaid
Children's Health Insurance Program

Request for Prior Authorization: Binge Eating Disorder Agents

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to the Prior Authorization of Benefits Center at **844-512-9004**. If you have questions or need assistance, call the Provider Help Desk at **800-454-3730**.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is required for Vyvanse for the treatment of Binge Eating Disorder (BED). Prior to requesting PA, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website at **https://pmp.iowa.gov/IAPMPWebCenter/**. Payment will be considered under the following conditions: 1) Patient is 18 to 55 years of age; 2) Patient meets the DSM-5 criteria for BED; 3) Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number must be reported); 4) Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes; 5) Prescription is written by a psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; 6) Patient has a BMI of 25 to 45; 7) Patient does not have a personal history of cardiovascular disease; 8) Patient has no history of substance abuse; 9) Is not being prescribed for the treatment of obesity or weight loss; and 10) Doses above 70mg per day will not be considered; 11) Initial requests will be approved for 12 weeks when criteria for coverage are met; 12) Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week.

☐ Vyvanse
☐ Other (specify):_____

Does member meet DSM-5 criteria for BED: ☐ No ☐ Yes (check all that apply below)

☐ Recurrent episodes of binge eating, including an abnormally large amount of food in a discrete period of time and has a feeling of lack of control over-eating

☐ Binge eating episodes are marked by at least three of the following:

- ☐ Eating more rapidly than normal
- ☐ Eating until feeling uncomfortably full
- ☐ Eating large amounts of food when not feeling physically hungry
- ☐ Eating alone because of embarrassment by the amount of food consumed
- ☐ Feeling disgusted with oneself, depressed, or guilty after overeating

☐ Episodes occur at least one day a week for at least three months

☐ No regular use of inappropriate compensatory behaviors (e.g., purging, fasting, or excessive exercise) as are seen in bulimia nervosa

☐ Does not occur solely during the course of bulimia nervosa or anorexia nervosa

Patient BMI:_____ Date Obtained:_____

Provide number of binge eating episodes per week prior to treat:_____

Does member have a history of substance abuse: ☐ Yes ☐ No

Does member have a personal history of cardiovascular disease: ☐ Yes ☐ No

Is requested medication being prescribed solely for the treatment of obesity or weight loss: ☐ **Yes** ☐ **No**

Document non-pharmacologic therapies tried including trial dates and failure reason:

Prescriber specialty: ☐ Psychiatrist ☐ Psychiatric Nurse Practitioner ☐ Psychiatric Physician Assistant

☐ **Other:**_____

Prescriber review of patient's controlled substance use on the Iowa PMP website: ☐ No ☐ Yes

Date reviewed**:**_____

Renewal requests:

Provide number of binge eating episodes per week while on treatment: _____

Pertinent lab data: _____

Other relevant information: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.