

Prescriber Criteria Form

Vyvanse 2025 PA Fax 3674-A v1 010125.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)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

<b>Please circle the appropriate answer for each question.</b>			
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:** \_\_\_\_\_