



**Independence  
Blue Cross**

**Prior Authorization Form**

**Vyvanse® (Lisdexamfetamine dimesylate)**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested:  **Vyvanse®**

Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**1. DIAGNOSIS FOR DRUG REQUESTED:**

- Attention deficit hyperactivity disorder (ADHD)
- Other (specify) \_\_\_\_\_

**2. MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

**3. PATIENT HISTORY**

a. Has **the patient tried and failed or has a contraindication/intolerance allergy any of the following?**

- Methylphenidate containing product  Yes  No
- Mixed amphetamine salts containing product (Adderall or Adderall XR)  Yes  No
- Strattera  Yes  No
- Dextroamphetamine containing product  Yes  No
- Desoxyn  Yes  No
- Dexmethylphenidate containing product  Yes  No

b. **Is there a history of or potential for drug abuse among the patient or the member of the household?**  Yes  No

Please add any other supporting medical information that may be useful in the decision-making process:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.**

<b>Internal use only</b>				<b>Coverage effective date</b> / /		
Document # _____				Processor Initials _____		Date _____
M	F	Rx coverage	Y	N	STANDARD - SELECT	LOB _____
Previous Auth				Y	N	<b>Approved</b> <b>Reviewer Initials</b> _____ <b>Date</b> _____