AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Binge Eating Disorder Agents

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:	Patient name:	
Patient address:		DOB:
Provider NPI:	Prescriber name:	Phone:
Prescriber address:		Fax:
Pharmacy name:		
Address:		Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI:	Pharmacy fax:	NDC:

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 or psychiatric nurse practitioner; 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.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

☐ **Vyvanse**

☐ **Other (specify)**

Strength: Dosage Form: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

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 1 day a week for at least 3 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:**

Provider number of binge eating episodes per week prior to treatment:

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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 reason for failure:

Prescriber specialty: ☐ Psychiatrist ☐ Psychiatric Nurse Practitioner ☐ Other

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

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.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

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.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.