ADD/ADHD, Binge Eating Disorder
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date:** ____________

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis-ICD code plus description:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested medication? .... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? ____________
2. Please list all agents the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products. Please specify start and end dates of drugs tried).
   ____________ Date(s): ________ ____________ Date(s): ________
   ____________ Date(s): ________ ____________ Date(s): ________
   ____________ Date(s): ________ ____________ Date(s): ________
3. Please list all other medications the patient will take **in combination** with the requested medication for the treatment of this diagnosis. ____________
4. Please list all reasons for selecting the requested **agent, strength, dosing schedule, and quantity over alternatives** (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). ____________

For IR and ER Formulations requests:

5. Does the patient have a history of substance abuse in the last 365 days? .... ☐ Yes ☐ No
6. Does the patient have a diagnosis of ADD/ADHD in the last 730 days? .... ☐ Yes ☐ No
7. Does the patient have a diagnosis of narcolepsy in the past 730 days? .... ☐ Yes ☐ No

For Vyvanse requests with a diagnosis of Binge Eating Disorder:

8. Does the patient have a diagnosis of ADD/ADHD in the last 730 days? .... ☐ Yes ☐ No
9. Does the patient have a diagnosis of narcolepsy in the last 730 days? .... ☐ Yes ☐ No
10. Does the patient have a diagnosis of binge eating disorder (BED) in the last 730 days? .... ☐ Yes ☐ No
11. Has the patient had at least 60 days of therapy with an agent for the treatment of Binge Eating Disorder (BED) in the last 60 days? .... ☐ Yes ☐ No
    If yes, please provide list of therapy agents: ____________
12. Does the patient have any of the following in the last 365 days? (check all that apply) .... ☐ Yes ☐ No
    ☐ history of substance abuse ☐ severe cardiac disease
    ☐ severe renal impairment ☐ end stage renal disease (ESRD)

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):

For Atomoxetine requests:

13. Does the patient have a diagnosis of bipolar disorder in the last 365 days? ☐ Yes ☐ No
14. Does the patient have a diagnosis of suicidal ideation or suicide attempt in the last 180 days? ☐ Yes ☐ No
15. Does the patient have a diagnosis of hepatic impairment in the last 180 days? ☐ Yes ☐ No
16. Does the patient have a history of severe cardiovascular disease in the last 365 days? ☐ Yes ☐ No
17. Does the patient have a diagnosis of pheochromocytoma or narrow angle glaucoma in the last 365 days? ☐ Yes ☐ No

For Qelbree requests:

18. Does the patient have a diagnosis of bipolar disorder in the last 365 days? ☐ Yes ☐ No
19. Does the patient have a diagnosis of suicidal ideation or suicide attempt in the last 180 days? ☐ Yes ☐ No

Prescriber or Authorized Signature: ______________________ **Date:** __________

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Please fax or mail this form to:
Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, Minnesota 55121

TOLL FREE
Fax: 877.243.6930 Phone: 855.457.0407

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