

TRICARE Prior Authorization Request Form for
Lisdexamfetamine capsule and chewable tablet (Vyvanse)



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To be completed and signed by the prescriber.



Clinical Documentation is required for a determination to be made.

Please fax completed form back to: (207) 828-7816

Prior authorization does not expire.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. For which diagnosis is the requested medication being prescribed?	<input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) - Proceed to question 2 <input type="checkbox"/> Moderate to severe Binge Eating Disorder- Proceed to question 5 <input type="checkbox"/> Weight loss/Obesity - STOP- Coverage not approved <input type="checkbox"/> Other indication or diagnosis- STOP- Coverage not approved	
2. Is the patient 6 years of age or older?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Has the patient tried and failed mixed amphetamine salts ER (Adderall XR, generics) or another long acting amphetamine or amphetamine derivative type drug?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Has the patient tried and failed methylphenidate OROS (Concerta, generics) or another long acting methylphenidate or methylphenidate derivative type drug?	<input type="checkbox"/> Yes Proceed to question 13	<input type="checkbox"/> No STOP Coverage not approved
5. Is the patient an Active Duty Service Member?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 7
6. Provider acknowledges the need to consult service specific policy for Binge Eating Disorder (BED).	<input type="checkbox"/> Acknowledged Proceed to question 7	
7. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved

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8. Was the requested medication prescribed by or in consultation with a psychiatrist or other behavioral specialist?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Has the patient failed, does not have access to, or had an inadequate response to cognitive behavioral therapy or other psychotherapy?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. Has the patient tried and failed OR had a contraindication to an SSRI (for example, citalopram, fluoxetine, sertraline)?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
11. Has the patient tried and failed OR had a contraindication to topiramate or zonisamide?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No STOP Coverage not approved
12. Provider acknowledges Vyvanse will be discontinued if the patient does not respond by having a positive clinical response, defined as a meaningful decrease of binge eating episodes or binge days per week from baseline, or improvement in signs and symptoms of binge eating disorder after taking Vyvanse.	<input type="checkbox"/> Acknowledged Proceed to question 13	
13. What is the requested medication?	<input type="checkbox"/> Vyvanse or lisdexamfetamine capsules – Sign and date below <input type="checkbox"/> Vyvanse or lisdexamfetamine chewable tablets – Proceed to question 14	
14. Provider acknowledges that brand Vyvanse formulation is the preferred product over generic lisdexamfetamine chewable tablet and is covered at the lowest copayment, which is the generic formulary copayment for non-Active-Duty patients, and at no cost share for Active-Duty patients. (Although Vyvanse is a branded product, it will be covered at the generic formulary copayment or cost share).	<input type="checkbox"/> Acknowledged Proceed to question 15	
15. What is the requested medication?	<input type="checkbox"/> brand Vyvanse Sign and date below	<input type="checkbox"/> other Proceed to question 16
16. Please provide a patient-specific justification as to why the brand Vyvanse cannot be used in this patient.	<div style="border-top: 1px solid black; text-align: right; padding-top: 5px;"> Sign and date below </div>	

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[10 December 2025]

Please attach office notes (clinical documentation)