



Fax Completed Form To
1.833.404.2392

Prescriber Help Desk
1.833.587.2012

Online

[covermy meds.com/main/
prior-authorization-forms/](http://covermy meds.com/main/prior-authorization-forms/)

**Request for Prior Authorization
VILOXAZINE (QELBREE)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Documentation of clinically significant impairment in two or more current environments (social, academic, or occupational).

Current Environment 1 & description: _____

Current Environment 2 & description: _____

Trial Documentation (atomoxetine or preferred stimulant):

Atomoxetine:

Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Preferred Stimulant:

Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

Renewals & newly eligible members established on medication

Date of most recent clinical visit confirming improvement in symptoms from baseline: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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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 Health and Human Services, that the member continues to be eligible for Medicaid.