Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization

VILOXAZINE (QELBREE)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
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 is required for viloxazine (Qelbree). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1) **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2) **Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and**
3) **Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational); and**
4) **Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine or a preferred stimulant; and**
5) **Dose does not exceed 400mg per day for pediatric patients (< 18 years of age) and 600mg per day for adult patients; and**
6) **Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD.**

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ **Qelbree**

Strength_____ **Dosage Instructions**_____ **Quantity**_____ **Days Supply**_____

Diagnosis: _____

Rating scale used to determine diagnosis: _____

Did patient have inattentive or hyperactive/impulsive symptoms present prior to age 12? ❑ Yes ❑ No

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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

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.*