







FAX Completed Form To 1.833.404.2392

Pharmacy Help Desk 1.800.460.8988

Prescriber Help Desk 1.833.587.2012

Request for Prior Authorization VILOXAZINE (QELBREE)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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IA Me	edicaid Mer	mber ID	#			Patient name				D	ОВ					
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 under the following conditions:															
) 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															
	Patient is between 6 and 17 years of age; and															
•	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															
	Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred amphetamine stimulant; and															
	Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred methylphenidate stimulant; and															
6) E																
7) I	Is dosed based on FDA approved dosing, and dose does not exceed 400mg per day; and															
	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.																
<u>Non</u>	Non-Preferred															
	Qelbree															
Stre	ngth			Do	sag	e Instructions		Qua	ntity	'	_ [Days	s Supp	oly_		
Diagnosis:																
Rati	ng scale	used t	o de	eter	mine	diagnosis:										
۸۵٥	of nation	t at ar	t	of a	.vm	ntoms:										

1/22 Page 1 of 2









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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: Preferred Amphetamine Stimulant:** Name/Dose:_____ Trial Dates:_____ Failure reason: **Preferred Methylphenidate Stimulant:** Name/Dose:_____ Trial Dates: _____ Failure reason: Atomoxetine: 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.

1/22 Page 2 of 2