UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Qelbree (viloxazine extended-release)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Is the patient 6 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD)? ❑ **Yes** ❑ **No**
3. Does the patient have a history of the following:? ❑ **Yes** ❑ **No**
    a. Failure/intolerance/contraindication to at least 2 preferred ADHD drugs from any of the below classes at a therapeutic dose, with a treatment duration of at least 4 weeks
        - ☐ Methylphenidate class stimulant and date of trial : _____
          Failure details: _____
        - ☐ Amphetamine class stimulant and date of trial: _____
          Failure details: _____
        - ☐ Non-stimulants for ADHD (clonidine ER or guanfacine ER) and date of trial:_____
          Failure details: _____

          AND
        - ☐ Failure/intolerance/contraindication to atomoxetine with a treatment duration of at least 3 months; date of trial: _____
          Failure details: _____

Reauthorization Criteria:

1. Has the provider submitted an updated letter with medical justification or updated chart notes demonstrating positive clinical response? Chart note page #: _____ ❑ **Yes** ❑ **No**

Initial Authorization: Up to one (1) year

Reauthorization: Up to one (1) year

Note:

- In clinical trials, higher rates of suicidal thoughts and behavior were reported in patients treated with Qelbree than in patients treated with placebe. Closely monitor for worsening and emergence of suicidal thoughts and behaviors.

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date