Iowa Department of Human Services

Request for Prior Authorization
VILOXAZINE (QELBREE)

IOWA Provider Services
1 (844) 236-1464

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195

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 under the following conditions:

1) **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**
2) **Patient is between 6 and 17 years of age; 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 at least one preferred amphetamine stimulant; and**
5) **Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred methylphenidate stimulant; and**
6) **Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine; and**
7) **Is dosed based on FDA approved dosing, and dose does not exceed 400mg per day; and**
8) **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: _____

Age of patient at onset of symptoms: _____

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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.*