AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Qelbree® (viloxazine)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is 6 years of age or older

AND

- ❑ Member must have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)

AND

(Continued on next page)

- ❑ Member must have a 30-day trial and failure with **BOTH** of the following **(verified by pharmacy paid claims; documentation of intolerance or treatment failure must be submitted)**:
  - ❑ amphetamine-based stimulant at up to maximally indicated doses, unless clinically significant adverse effects are experienced to any amphetamine product or all are contraindicated
  - ❑ methylphenidate-based stimulant at up to maximally indicated doses, unless clinically significant adverse effects are experienced to any methylphenidate product or all are contraindicated

AND

- ❑ Member must have a 30-day trial and failure of atomoxetine (Strattera) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced **AND** one of the following **(verified by pharmacy paid claims; documentation of intolerance or treatment failure must be submitted)**:
  - ❑ guanfacine ER (Intuniv) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced
  - ❑ clonidine ER (Kapvay) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****