Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Qelbree (viloxazine) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Qelbree (viloxazine).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Does the patient have a diagnosis of Attention Deficit Hyperactivity isorder (ADHD) as confirmed by psychoeducational testing***?
   □ No □ Yes

2. Is the patient ≥6 years of age?
   □ No □ Yes

3. Does the patient meet ONE of the following?
   a. Adequate trial* (1 week) and/or intolerance** or allergy to atomoxetine,
   b. OR patient is unable to swallow a solid dosage form (i.e. an oral tablet or capsule) due to age, oral/motor difficulties, or dysphagia
   □ No □ Yes

Notes:

**Atomoxetine should be titrated to effect. Use the 10, 18 or 25 mg strengths for titration.*

***Intolerance excludes adverse drug reactions that are expected, mild in nature, resolve with continued treatment and do not require medication discontinuation*

****Criteria only applies for 18 years of age and older*

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Does the patient continue to meet initial review criteria?
   □ No □ Yes

2. Has the patient demonstrated positive clinical response to medication?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**