

SENTARA HEALTH PLANS

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 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Qelbree® (viloxazine)

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

Member Name: _____

Member Sentara #: _____ 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: _____

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

- 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

(Continued on next page.)

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.****