TEXAS MEDICAID
Clinical Edit Prior Authorization
viloxazine (QELBREE)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client less than (<) 6 years of age?

   ☐ Yes (Deny) ☐ No (Go to #2)

2. Is the client greater than (>) 17 years of age?

   ☐ Yes (Deny) ☐ No (Go to #3)

3. Does the client have a diagnosis of bipolar disorder in the last 365 days?

   ☐ Yes (Go to #4) ☐ No (Go to #5)

4. Does the client have a claim for a mood stabilizer in the last 90 days?

   Examples of mood stabilizers include: aripiprazole (ABILIFY, ABILIFY MAINTENA ER, ABILIFY MYCITE), asenapine (SAPHRIS), carbamazepine (CARBATROL ER, EPITOL, EQUETRO, TEGRETOL, TEGRETOL XR), divalproex (DEPAKOTE, DEPAKOTE ER), lamotrigine (LAMICTAL, LAMICTAL XR, SUBVENITE), LATUDA, lithium carbonate (LITHOBID ER), olanzapine (ZYPREXA), quetiapine (SEROQUEL, SEROQUEL XR), risperidone (RISPERDAL, RISPERDAL CONSTA), olanzapine/fluoxetine (SYMBYAX), VRAYLAR, and ziprasidone (GEODON)

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have a diagnosis of suicidal ideation or suicide attempt in the last 180 days?

☐ Yes (Deny) ☐ No (Go to #6)

6. Has the client been on a monoamine oxidase (MAO) inhibitor in the last 14 days?

Examples of MAO inhibitors include: linezolid (ZYVOX), MARPLAN, phenelzine (NARDIL), rasagiline mesylate (AZILECT), selegiline (EMSAM, ZELAPAR), and tranylcypromine (PARNATE)

☐ Yes (Deny) ☐ No (Go to #7)

7. Does the client have a claim for a sensitive CYP1A2 substrate or a CYP1A2 substrate with a narrow therapeutic index (NTI) in the last 30 days?

Examples of CYP1A2 substrates include: alosetron (LOTRONEX), duloxetine HCL (CYMBALTA), HETLIOZ, ramelteon (ROZEREM), theophylline (ELIXOPHYLLINE, THEO-24), tizanidine, warfarin (COUMADIN, JANTOVEN)

☐ Yes (Deny) ☐ No (Go to #8)

8. Does the client have a diagnosis of hepatic impairment in the last 180 days?

☐ Yes (Deny) ☐ No (Go to #9)

9. Is the requested dose less than or equal to (≤) 2 units per day?

☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.