Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD): viloxazine (QELBREE)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Clinical Criteria (required)

10. Is the member less than (<) six (6) years of age?

- ◯ Yes (Deny)
  (Go to #11)
- ◯ No
  (Go to #11)

11. Does the member have a diagnosis of bipolar disorder in the last 365 days?

- ◯ Yes
  (Go to #12)
- ◯ No
  (Go to #13)

12. Does the member have a claim for a mood stabilizer in the last 90 days?

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

- ◯ Yes
  (Go to #13)
- ◯ No (Deny)
  (Go to #13)

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

- ◯ Yes (Deny)
  (Go to #14)
- ◯ No
  (Go to #14)

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

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

- ◯ Yes (Deny)
  (Go to #15)
- ◯ No
  (Go to #15)

15. Does the member have a claim for a sensitive CYP1A2 substrate or a CYP1A2 substrate with a narrow therapeutic index in the last 30 days?

Examples of sensitive CYP1A2 substrate & CYP1A2 substrate with a narrow therapeutic index include: alosetron (LOTRONEX), duloxetine (CYMBALTA), ramelteon (ROZEREM), tasimelteon (HETLIOZ), theophylline (ELIXOPHYLLINE, THEO-24), tizanidine (ZANAFLEX), warfarin (COUMADIN, JANTOVEN)

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

16. Does the member have a diagnosis of hepatic impairment in the last 180 days?

- ◯ Yes (Deny)
  (Go to #17)
- ◯ No
  (Go to #17)

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

- ◯ Yes (Approve - 365 days)
  (Go to #19)
- ◯ No - and the member is greater than or equal to (≥) 18 years of age
  (Go to #18)
- ◯ No - and the member is less than (<) 18 years of age (Deny)
  (Go to #19)

18. Is the requested dose less than or equal to (≤) three (3) units per day?

- ◯ Yes (Approve - 365 days)
  (Go to #19)
- ◯ No (Deny)
  (Go to #19)

Additional Information

19. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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