TRICARE Prior Authorization Request Form for
viloxazine **(Qelbree)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: _____ Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)? **Note: Non-FDA approved uses are NOT approved (to include depression or anxiety).**	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. How old is the patient?	☐ Greater than or equal to 18 years of age – **Proceed to question 5** ☐ Between 6 to 17 years of age – **Proceed to question 3** ☐ Younger than 6 years of age – **STOP Coverage not approved**	
3. Does the patient have a documented medical condition (for example, dysphagia, oral candidiasis, systemic sclerosis, autism spectrum disorder, etc.) where they are not able to swallow?	☐ Yes **Proceed to question 7**	☐ No **Proceed to question 4**
4. Has the patient tried and failed, had an inadequate response, OR contraindication to at least one non-stimulant ADHD medications (generic formulations of Strattera, Kapvay, or Intuniv)?	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed, had an inadequate response, OR contraindication to atomoxetine (generic of Strattera)?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**

6. Has the patient tried and failed, had an inadequate response, OR contraindication to at least one other non-stimulant ADHD medications (generic formulations of Kapvay or Intuniv)?	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed, had an inadequate response, OR contraindication to amphetamine salts XR (Adderall XR, generic) or other long acting amphetamine or derivative drug?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried and failed, had an inadequate response, OR contraindication to methylphenidate OROS (Concerta, generics) or another long acting methylphenidate or methylphenidate derivative type drug?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[09 December 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: