# US Family Health Plan
# Prior Authorization Request Form for
# viloxazine **(Qelbree)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

**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:**

| Question | | |
|---|---|---|
| **1. Does the patient have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)?**<br>**Note: Non-FDA approved uses are NOT approved (to include depression or anxiety).** | ☐ Yes<br>**Proceed to question 2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. How old is the patient?** | ☐ Greater than or equal to 18 years of age – **Proceed to question 5**<br>☐ Between 6 to 17 years of age – **Proceed to question 3**<br>☐ 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<br>**Proceed to question 7** | ☐ No<br>**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<br>**Proceed to question 7** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Has the patient tried and failed, had an inadequate response, OR contraindication to atomoxetine (generic of Strattera)?** | ☐ Yes<br>**Proceed to question 6** | ☐ No<br>**STOP**<br>**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<br>**Proceed to question 7** | ☐ No<br>**STOP**<br>**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<br>**Proceed to question 8** | ☐ No<br>**STOP**<br>**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<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3**

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

_________________________________ Prescriber Signature

____________ Date