UnitedHealthcare Community Plan

ADHD/Anti-Narcolepsy: Non-Stimulants Qelbree (Viloxazine) - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: ______________

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ________________

Section B - Provider Information

First Name:	Last Name: M.D./D.O.		
Address:	City:	State:	ZIP code:
Phone: Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:			

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? ______________**

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   - If yes, is there documentation demonstrating improvement or stabilization in signs and symptoms of ADHD (e.g., inattention, hyperactivity, behavior)? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Attention Deficit Hyperactivity Disorder (ADHD)
   ☐ Other. Specify: ______________________________

3. List all medications the patient has previously tried or has a history of failure, intolerance and/or contraindication. (Include the duration of use and reason for discontinuation or contraindication for each medication.)
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Chart notes are required with this request

Prescriber signature	Prescriber specialty	Date

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