UnitedHealthcare Community Plan

Anticonvulsants - Nebraska
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 for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
☐ **Yes** ☐ **No**	**Is the request for continuation of prior therapy for a seizure disorder?** *If yes, list start date:*
☐ **Yes** ☐ **No**	**Does the patient have one of the following diagnoses? (If yes, check which applies)** ☐ Partial-onset seizures ☐ Complex Partial seizures ☐ Infantile Spasms
☐ **Yes** ☐ **No**	**Does the patient have a diagnosis of partial-onset seizures with or without secondarily generalized seizures or primary generalized tonic-clonic seizures?**
☐ **Yes** ☐ **No**	**Is there history of greater than or equal to 8 week trial of any of the following (any release formulation qualifies)?** *(If yes, check which applies and complete Section D above)* ☐ Carbamazepine ☐ Divalproex ☐ Gabapentin ☐ Lamotrigine ☐ Levetiracetam ☐ Oxcarbazepine ☐ Phenytoin ☐ Pregabalin ☐ Topiramate ☐ Valproic acid ☐ Zonisamide
☐ **Yes** ☐ **No**	**Is there <u>both</u> of the following?** *(If yes, check which applies and complete Section D above)* ☐ Documented history of persisting seizures after titration to the highest tolerated dose with each medication trial ☐ Lack of compliance as a reason for treatment failure has been ruled out
☐ **Yes** ☐ **No**	**Is there <u>both</u> of the following?** *(If yes, check which applies and complete Section D above)* ☐ Documentation of failure due to intolerable side effects ☐ Reasonable efforts were made to minimize the side effect (e.g. change timing of dosing, divide dose out for more frequent but smaller doses, etc.)
ONFI / BANZEL / FELBATOL	
☐ **Yes** ☐ **No**	**Does the patient have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)?**
GABITRIL	
☐ **Yes** ☐ **No**	**Will this be used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)?**
EPIDIOLEX	
☐ **Yes** ☐ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* ☐ Seizures associated with Dravet syndrome ☐ Seizures associated with Lennox-Gastaut Syndrome
SABRIL	
☐ **Yes** ☐ **No**	**Will Sabril be used as adjunctive therapy?** If yes, list medication:
SYMPAZAN	
☐ **Yes** ☐ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* ☐ Seizures associated with Lennox-Gastaut syndrome (LGS) ☐ Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)
☐ **Yes** ☐ **No**	**Is there both of the following?** *(If yes, check which applies and complete Section D above)* ☐ Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment.) ☐ Not used as primary treatment

Provider Signature: ______________________________ **Date:** ______________

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