

Pharmacy Prior Authorization Form

Last Reviewed: May 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Banzel[®] (rufinamide) Urgent Non-urgent

| | |
|-------------------------------|-----------------|
| Member Name: | Member #: |
| DOB: | Gender: |
| Provider Name: | Provider Phone: |
| Provider Office Address: | |
| Provider Office Contact Name: | Provider Fax: |
| Provider Signature: | Provider NPI: |
| Date: | Member's PCP: |

Product:

Banzel 200 mg 400 mg

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of Banzel requires:

- Diagnosis of Lennox-Gastaut Syndrome in patients 4 years and older **AND**
- Adjunctive treatment with other anti-epileptics

Diagnosis:

- Lennox-Gastaut Syndrome
- Other adjunct anti-epileptic therapies: _____

Other Diagnosis: _____

Please provide rationale for use:

Patient's age: _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX