

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Commercial (Traditional) Commercial (Individual/Optimized)

Medicaid

This request is: Urgent (life threatening) Non-Urgent (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Aptiom[®] (eslicarbazepine)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

New request Continuation request

Drug product: Aptiom 200mg tablet
 Aptiom 400mg tablet
 Aptiom 600mg tablet
 Aptiom 800mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of partial-onset seizure (please provide documentation)
2. Trial and failure with or intolerance to all of the following:
 - Oxcarbazepine
 - One additional generic anti-seizure medication
3. Minimum age of 4 years

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

Priority Health Precertification Documentation

A. The condition the drug is being requested for:

Partial-onset seizure (documentation provided to support diagnosis)

Other – the patient's condition is: _____

Rationale for use: _____

B. The patient has tried the following medications:

Drug	Dose	Dates of Use	Therapy Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. The patient is at least 4 years of age:

- Yes
- No