PriorityHealth

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.

Briviact® (brivaracetam)

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:

- ☐ Briviact 10mg tablet
- ☐ Briviact 25mg tablet
- ☐ Briviact 50mg tablet
- ☐ Briviact 75mg tablet
- ☐ Briviact 100mg tablet
- ☐ Briviact 10mg/mL Oral Solution

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 Levetiracetam
3. Minimum age of 4 years

Note: Authorization for indications, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used 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: ______________________

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 08/2018
Last reviewed 03/2019

B. The patient has tried the following anti-seizure medications:

Drug	Dose	Dates of Use	Therapy Outcome

☐ Not all requirements are met – Below is rationale for use:

____

C. Briviact will be used as adjunctive therapy with the following anti-seizure medication(s):

Drug	Dose

D. The patient is at least 16 years of age:

☐ Yes
☐ No

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Updated 08/2018
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