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 the following requirements:

1. Must have a diagnosis of partial-onset seizure (please provide documentation)
2. Must have had a trial and failure with or intolerance to levetiracetam
3. Must be at least 4 years of age

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 03/2020
Last reviewed 03/2020

B. Has the patient tried and failed or had intolerance to levetiracetam?

☐ Yes. **Dates of use:** _____ **Outcome:** _____

☐ No. Rationale for use: _____

C. Is the patient at least 4 years of age?

☐ Yes

☐ No. Rationale for use: _____

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Updated 03/2020
Last reviewed 03/2020