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.

Oxtellar XR® (oxcarbazepine)

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:
- ☐ Oxtellar XR 150mg tablet
- ☐ Oxtellar XR 300mg tablet
- ☐ Oxtellar XR 600mg 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 fax supporting documentation of diagnosis along with request for coverage
2. Trial and failure with or intolerance to all of the following:
   - Oxcarbazepine
   - One additional generic anti-seizure medication
3. Will use Oxtellar XR as adjunctive therapy with one other anti-seizure medication
4. Minimum age of 6 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.

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

New 07/2017
Last reviewed 07/2018

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
________	________	________	________________
________	________	________	________________
________	________	________	________________
________	________	________	

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

____

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

Drug	Dose
________	________
________	________
________	________
________	________

D. The patient is at least 6 years of age:

☐ Yes
☐ No

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New 07/2017
Last reviewed 07/2018