HEALTH PLANS
UNIVERSITY OF UTAH

# PRIOR AUTHORIZATION REQUEST FORM
## BRAND ANTICONVULSANTS
Briviact®, Fycompa™, Vimpat®, Xcopri®

**For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.**

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

| | | |
|---|---|---|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |
| Height/Weight: | | |

***Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.***

**Product being requested:** ☐ Briviact® (brivaracetam), ☐ Fycompa™ (perampanel), ☐ Vimpat® (lacosamide), ☐ Xcopri® (cenbamate)

Dosing/Frequency:_____

**If the request is for reauthorization, proceed to reauthorization section**

| Questions | Yes | No | Comments/Notes |
|---|---|---|---|
| **PARTIAL-ONSET SEIZURES** | | | |
| 1. Does the member have a confirmed diagnosis of partial-onset seizures? | ☐ | ☐ | **Please provide documentation** |
| 2. Is the prescriber a neurologist or neuro-oncologist? | ☐ | ☐ | |
| 3. Does the member meet the age requirement per FDA approved package labeling? | ☐ | ☐ | |
| 4. Has the member tried and failed at least 2 other anticonvulsant(s)? (Only 1 other anticonvulsant is required in patients with brain tumors) | ☐ | ☐ | **Please provide documentation** |
| **TONIC-CLONIC SEIZURES** | | | |
| 1. Does the member have a confirmed diagnosis of tonic-clonic seizures? | ☐ | ☐ | **Please provide documentation** |
| 2. Is the prescriber a neurologist or neuro-oncologist? | ☐ | ☐ | |
| 3. Does the member meet the age requirement per FDA approved package labeling? | ☐ | ☐ | |
| 4. Has the member tried and failed at least 2 other anticonvulsant(s)? (Only 1 other anticonvulsant is required in patients with brain tumors) | ☐ | ☐ | **Please provide documentation** |
| **REAUTHORIZATION** | | | |
| 1. Is the request for reauthorization of therapy? | ☐ | ☐ | |

| | | | |
|---|---|---|---|
| 2. Has the member's therapy been re-evaluated within the last 12 months? | ☐ | ☐ | |
| 3. Does the member show a continued medical need for the therapy and is tolerating treatment? | ☐ | ☐ | **Please provide documentation** |
| 4. Does updated documentation show improvement or stabilization in the member's condition? | ☐ | ☐ | **Please provide documentation** |

**What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.**

Additional information:

Physician's Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM-095
Origination Date: 02/27/2020
Reviewed/Revised Date: 01/27/2021
Next Review Date: 01/27/2022
Current Effective Date: 02/01/2021