UnitedHealthcare Community Plan

Anticonvulsants
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: ______________

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ________________

Section B - Provider Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? _______________**

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
Number of Seizures per month:	
☐ Yes ☐ No	**Is the request for continuation of prior therapy for a seizure disorder?** *If yes, list start date:*
☐ Yes ☐ No	**Does the patient have a one of the following diagnoses?** *(If yes, check which applies)* ☐ Partial-onset seizures with or without secondarily generalized seizures ☐ Primary generalized tonic-clonic seizures ☐ Seizures associated with Lennox-Gastaut syndrome ☐ Seizures associated with Dravet syndrome ☐ Infantile spasms ☐ Complex partial seizures ☐ Refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)
☐ Yes ☐ No	**Is there history of greater than or equal to 8-week trial of any of the following (any release formulation qualifies):** *(If yes, check all that apply and complete Section D above)* ☐ Carbamazepine ☐ Banzel ☐ Divalproex ☐ Divalproex ☐ Felbamate ☐ Gabapentin ☐ Lamotrigine ☐ Levetiracetam ☐ Oxcarbazepine ☐ Phenytoin ☐ Pregabalin ☐ Topiramate ☐ Valproic acid ☐ Zonisamide
☐ Yes ☐ No	**Is there both of the following:** ☐ Documented history of persisting seizures after titration to the highest tolerated dose with each medication trial ☐ Lack of compliance as a reason for treatment failure has been ruled out
☐ Yes ☐ No	**Is there both of the following:** ☐ Documentation of failure due to intolerable side effects ☐ Reasonable efforts were made to minimize the side effect (e.g. change timing of dosing, divide dose out for more frequent but smaller doses, etc.)
GABITRIL / SYMPAZAN / SABRIL	
☐ Yes ☐ No	**Will this be used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)?**
DIACOMIT	
☐ Yes ☐ No	**Is the patient currently taking clobazam?**

Provider Signature: ____ **Date:** ___________________

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