Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Nonpreferred Anti-Epileptic Drugs Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Nonpreferred Anti-Epileptic Drugs.** This PA form includes **Aptiom (eslicarbazepine), Brivact (brivaracetam), Felbatol (felbamate), Fycompa (perampanel), Banzel (rufinamide), Onfi (clobazam), Sympazan (clobazam), Sabril (vigabatrin), Diacomit (stiripentol).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a neurologist ? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Does the patient have a history of ≥ 8-week trial of at least 2 of the following (any release formulation qualifies): carbamazepine, divalproex, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, pregabalin, topiramate, valproic acid, zonisamide?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Is there documentation of positive clinical response to therapy?
   □ No □ Yes

2. Has the patient had an office visit or telephone visit with neurologist within the past 12 months?
   □ No □ Yes

7 – Provider Sign-Off

Additional Information

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility