pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTICONVULSANTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Anticonvulsants** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total pages: ____________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Aptiom tablet	☐Dilantin suspension	☐Lamictal chewable tablet	☐Neurontin capsule	☐Topamax tablet
☐Briviact solution	☐Equetro capsule	☐Lamictal tablet starter kit	☐Neurontin solution	☐topiramate ER sprinkle
☐Briviact tablet	☐felbamate suspension	☐Lamictal tablet	☐Neurontin tablet	☐Trileptal suspension
☐Carbatrol ER capsule	☐felbamate tablet	☐Lamictal ODT	☐Onfi suspension	☐Trileptal tablet
☐clonazepam ODT	☐Felbatol suspension	☐Lamictal ODT starter kit	☐Oxtellar XR tablet	☐Trokendi XR capsule
☐Depakene capsule	☐Felbatol tablet	☐Lamictal XR tablet	☐Phenytek capsule	☐vigabatrin powder
☐Depakene solution	☐Fycompa suspension	☐Lamictal XR starter kit	☐Qudexy XR sprinkle	☐Zarontin capsule
☐Depakote DR tablet	☐Fycompa tablet	☐lamotrigine ER tablet	☐Sabril powder packet	☐Zarontin solution
☐Depakote ER tablet	☐gabapentin solution	☐lamotrigine ODT	☐Sabril tablet	☐Zonegran capsule
☐Depakote sprinkle	☐Keppra solution	☐lamotrigine ODT kit	☐Spritam tab for susp.	☐________________
☐Diastat rectal gel	☐Keppra tablet	☐levetiracetam ER tablet	☐Tegretol XR tablet	________________
☐Dilantin 100 mg capsule	☐Keppra XR tablet	☐Lyrica solution	☐tiagabine tablet	
☐Dilantin Infatab	☐Klonopin tablet	☐Mysoline tablet	☐Topamax sprinkle	

Strength:	Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):	

1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Anticonvulsants? *Check all that apply.*

☐Banzel suspension or tablet	☐divalproex ER tablet	☐Peganone tablet
☐carbamazepine chewable, suspension, or tablet	☐Epitol tablet	☐phenobarbital elixir/solution or tablet
☐carbamazepine suspension	☐ethosuximide capsule or sol'n	☐phenytoin capsule, chewable, or suspension
☐carbamazepine ER capsule	☐gabapentin capsule or tablet	☐primidone tablet
☐carbamazepine XR tablet	☐Gabitril tablet	☐Tegretol suspension or tablet
☐Celontin Kapseal	☐lamotrigine chewable or tablet	☐topiramate (IR) sprinkle
☐clonazepam tablet	☐levetiracetam solution or tablet	☐topiramate tablet
☐diazepam rectal gel	☐Lyrica capsule	☐valproic acid capsule or solution
☐Dilantin 30 mg capsule	☐Onfi tablet	☐Vimpat solution or tablet
☐divalproex DR sprinkle or tablet	☐oxcarbazepine susp'n or tablet	☐zonisamide capsule

☐Yes → *Submit documentation of drug regimens tried and failed, contraindications, and/or intolerances.*

☐No

2. Has the beneficiary taken the requested non-preferred medication in the past 90 days?

☐Yes → *Submit documentation of drug regimen and clinical response.*
☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION.

Prescriber Signature:	**Date**:

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