



**Eprontia (topiramate oral solution)
Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640



Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Epilepsy <input type="checkbox"/> Migraine <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>Is this drug being used as part of a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested dose not available in another formulation (tablets, capsules, or sprinkle capsules)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide dose being requested</i></p> <p>Does the patient have an enteral feeding tube? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have difficulty swallowing? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit chart documentation</i></p> <p>Is the patient taking any other tablets or capsules(excluding sprinkle capsules)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For <u>epilepsy</u>, please answer the following: Is the medication being used for initial monotherapy for the treatment of partial-onset or primary generalized tonic-clonic seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the medication being used as adjunctive therapy for the treatment of partial-onset seizures, primary generalized tonic-clonic seizures, and seizures associated with Lennox-Gastaut syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For <u>migraine</u>, please answer the following: Is the medication being used for prevention? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For <u>Renewal</u>, please answer the following: Is the requested dose not available in another formulation (tablets, capsules, or sprinkle capsules)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have an enteral feeding tube? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have difficulty swallowing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient taking any other tablets or capsules(excluding sprinkle capsules)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		





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**Is the patient experiencing symptom improvement or symptom maintenance with the requested medication?
(Documentation required) Yes No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP - 4201

P.O. Box 64811

St. Paul, MN 55164-0811

