

Fycompa (perampanel) 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.

			URGEN	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:	DATE OF BIRTH:	
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
PATIENT INSURANCE ID	NUMBER:			
MALE FEMALE	HEIGHT (IN/CM): W	EIGHT (LB/KG): ALLE	ERGIES:	
		DISCLOSURE AUTHORIZATION FORM WITH THI OMMON/DOC/EN-US/PHI_DISCLOSURE_AUTH		
		BLE):		
PRESCRIBER INFORMATI	ON			
LAST NAME:		FIRST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:	FAX NUMBER:	
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSO	OFFICE CONTACT PERSON:	
		1		
MEDICATION OR MEDIC	AL DISPENSING INFORMATIO	N		
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
□ NEW THERAPY □ RENEWAL DURATION OF THERAPY (SPECIFIC DATES):		IF RENEWAL: DATE THER	IF RENEWAL: DATE THERAPY INITIATED:	
Continued on next page.				

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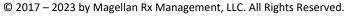
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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY	DURATION OF THERAPY (SPECIFY	RESPONSE/REASON FOR		
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:		
•	,			
2. LIST DIAGNOSES:		ICD-10:		
□ Partial-onset seizures				
☐ Primary generalized tonic-clonic seizures				
□ Other Diagnosis ICD-10 Co				
	: PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A		
PRIOR AUTHORIZATION.				
Clinical information:				
Is the medication being prescribed by	a neurologist? □ Yes □ No			
Will Fycompa be used as monotherapy	y? □ Yes □ No			
Is the patient concurrently taking at le	ast one other anticonvulsant medication	on? □ Yes □ No		
-	nticonvulsant medications? □Yes □ No			
Please provide documentation.				
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	e 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 be	st of my knowledge. I understand that		
the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical				
-	uracy of the information reported on th	•		
Prescriber Signature or Electronic I.D.		Date:		
	ompanying this transmission contain confidential			
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 decuments is strictly prohibited. If you have received this information in error, places notify the conder immediately (via return EAX)				
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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



and arrange for the return or destruction of these documents.

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