

## **Xcopri (cenobamate) Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit

**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 NUM	/IBER:		1		
MALE FEMALE HEIG				_	
IF YOU ARE NOT THE PATIENT OR THE PRESCRI FOLLOWING LINK: <u>HTTPS://MAGELLANRX.COM</u>					
PATIENT'S AUTHORIZED REPR	ECENITAT	IVE (IE ADDI ICARI E)			
AUTHORIZED REPRESENTATIV					
PRESCRIBER INFORMATION					
LAST NAME:			FIRST NAME:		
PRESCRIBER SPECIALTY:			EMAIL ADDRESS:		
NPI NUMBER:			DEA NUMBER:		
PHONE NUMBER:			FAX NUMBER:		
STREET ADDRESS:			1		
CITY:			STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):			OFFICE CONTACT PERSON:		
			•		
MEDICATION OR MEDICAL I	DISPENSI	NG INFORMATION			
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUE	NCY:	LENGTH OF	_	QUANTITY:
		7	THERAPY/REFILI		
DURATION OF THERAPY (SPE	<b>│ RENEWAL</b> 'ES):	IF RENEWAL: DATE THERAPY INITIATED:			
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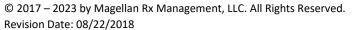
Caterpillar Prescription Drug Benefit

Caterpinar Prescription Drug Benefit						
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NC				
MEDICATION/THERAPY (SPECIFY	<b>DURATION OF THERAPY</b> (SPECIFY	RESPONSE/REASON FOR				
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:				
2. LIST DIAGNOSES:		ICD-10:				
☐ Parial-onset seizure						
□ Other diagnosis:ICD-						
3. REQUIRED CLINICAL INFORMATION:	: PLEASE PROVIDE ALL RELEVANT CLINICA	AL INFORMATION TO SUPPORT A				
PRIOR AUTHORIZATION.						
Clinical Information:						
Is this drug being prescribed to this pa	tient as part of a treatment regimen spe	ecified within a sponsored clinical				
trial? □ Yes □ No						
Is prescriber a neurologist? ☐ Yes ☐ I	No					
Is Xcopri(cenobamate) going to be use	d as monotherapy? □ Yes □ No					
	obamate) concomitantly with at least o	one other anticonvulsant medication?				
□ Yes □ No	obamate, concomitantly with at reast o	The other unitions also medication.				
	other anticonvulsant medications? $\ \ \Box$ Y	es   No Please provide				
documentation.						
Ave there are other comments diagra	and aumentains modications tried or fo	iled and/or any other information the				
· · · · · · · · · · · · · · · · · · ·	oses, symptoms, medications tried or fa	iled, and/or any other information the				
physician feels is important to this rev	lew r					
·						
	re covered on all plans. This request may	be denied unless all required				
information is received.						
	provided is true and accurate to the bes	,				
· · · · · · · · · · · · · · · · · · ·	or its designees may perform a routine					
information necessary to verify the acc	uracy of the information reported on thi	s form.				
Prescriber Signature or Electronic I.D.	Verification:	Date:				
	ompanying this transmission contain confidential					
	eby notified that any disclosure, copying, distribut					
of these documents is strictly prohibited. If you	have received this information in error, please no	otify the sender immediately (via return FAX)				

**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.

1. -----

CAT0295



