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: PRIMETHERAPEUTICS.COM/NOPP

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:**
☐ **NEW THERAPY**	☐ **RENEWAL**	**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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MEMBER'S LAST NAME: ___________________________ **MEMBER'S FIRST NAME:** ___________________________

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?	☐ YES (if yes, complete below)	☐ NO
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Epilepsy □ Migraine □ Other diagnosis: ________________ICD-10________________________	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is this drug being used as part of a clinical trial? □ Yes □ No

Is the requested dose not available in another formulation (tablets, capsules, or sprinkle capsules)? □ Yes □ No
Please provide dose being requested

Does the patient have an enteral feeding tube? □ Yes □ No

Does the patient have difficulty swallowing? □ Yes □ No *Please submit chart documentation*

Is the patient taking any other tablets or capsules(excluding sprinkle capsules)? □ Yes □ No

For epilepsy, please answer the following:
Is the medication being used for initial monotherapy for the treatment of partial-onset or primary generalized tonic-clonic seizures? □ Yes □ No

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? □ Yes □ No

For migraine, please answer the following:
Is the medication being used for prevention? □ Yes □ No

For Renewal, please answer the following:
Is the requested dose not available in another formulation (tablets, capsules, or sprinkle capsules)? □ Yes □ No

Does the patient have an enteral feeding tube? □ Yes □ No

Does the patient have difficulty swallowing? □ Yes □ No

Is the patient taking any other tablets or capsules(excluding sprinkle capsules)? □ Yes □ No

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

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Prime THERAPEUTICS™

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

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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:** ________________

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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