

Sabril® – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free at 866-249-6155.** If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery, please contact the Specialty Customer Care Team: CaremarkConnect® 800-237-2767.

Patient Name:	Date:
Patient's ID:	Patient's Date of Birth:
Physician's Name:	
Specialty:	NPI#:
Physician Office Telephone:	Physician Office Fax:

1. What drug is being prescribed? Sabril® Other _____
2. What is the patient's diagnosis?
 - Infantile spasms
 - Complex partial seizures
 - Other _____
3. What is the ICD code? _____
4. What is the patient's age? _____ months/years (circle one)
5. What is the patient's weight? _____ **provide units**
6. Is the patient currently on Sabril® therapy? Yes No *If No, skip to diagnosis section.*
7. Has the patient shown substantial clinical benefit from Sabril therapy? Yes No *No further questions*

Complete the following section based on the patient's diagnosis.

Section A. Infantile Spasms

8. Is Sabril® used as a single agent in the treatment of infantile spasms? Yes No

Section B. Complex Partial Seizures

9. Is Sabril® being used as adjunctive therapy for complex partial seizures? Yes No
10. Has the patient had an inadequate response to at least 2 alternative treatments (eg. carbamazepine [Carbatrol®, Eptitol®, Equetro®, Tegretol®, Teri®] or phenytoin [Dilantin®, Phenytek®]) for complex partial seizures? Yes No
If Yes, document previous treatments: _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature **Date: (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Sabril SGM – 11/2014