



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Sabril

Prior Authorization Request

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 toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

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

1. What drug is being prescribed? Sabril, Dose: _____ Frequency: _____ Other _____
2. What is the diagnosis?
 Infantile spasms
 Complex Partial Seizures
 Other _____
3. **What is the ICD-9 code?** _____
4. Was the vision assessed at baseline, or will the vision be assessed by an ophthalmologist no longer than 4 weeks after starting Sabril? Yes No **If no, skip to # 7*
5. Is the patient at high risk for having, or does the patient have other types of irreversible vision loss?
 Yes No
6. Is the patient using other medications associated with serious adverse ophthalmic effects such as retinopathy or glaucoma? Yes No
7. Does the patient have pre-existing blindness? Yes No
8. Is the patient currently on Sabril therapy? **If yes, skip to # 15* Yes No
9. How old is the patient? _____ **years**
10. Sabril is being used as: Monotherapy Adjunctive therapy
11. Is the diagnosis complex partial seizures? Yes No **If no, no further questions.*
12. Is the patient refractory to other antiepileptic drugs? Yes No
13. Has the patient failed an adequate regimen with either carbamazepine or phenytoin? Yes No
14. If no, was the patient intolerant to or was the use of carbamazepine or phenytoin contraindicated in this patient? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

Only answer below question if patient is currently on Sabril

15. Has the patient shown substantial clinical benefit from Sabril therapy? Yes No
16. Will the patients' vision be assessed every 3 months by an ophthalmologist? Yes No

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

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

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