Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Nonpreferred Anti-Epileptic Drugs Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Nonpreferred Anti-Epileptic Drugs.** This PA form includes **Aptiom (eslicarbazepine), Brivact (brivaracetam), Felbatol (felbamate), Fycompa (perampanel), Banzel (rufinamide), Onfi (clobazam), Sympazan (clobazam), Sabril (vigabatrin), Diacomit (stiripentol).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Is the prescriber a neurologist ? □ No □ Yes

If consulted with a specialist, specialist name and specialty: ____

Provider Name: ______________________________ Specialty: _____________________________ NPI: ________________

Provider Address: ____

Provider Phone #: __________________________Provider Fax #: ___________________________

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: ________________

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____
Sig: ____

Drug 2: Name/Strength/Formulation: ____
Sig: ____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: ___________________________________

2. Indicate the patient's diagnosis for the requested medication: ____

Clinical Criteria:

1. Does the patient have a history of ≥ 8-week trial of at least 2 of the following (any release formulation qualifies): carbamazepine, divalproex, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, pregabalin, topiramate, valproic acid, zonisamide?
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Is there documentation of positive clinical response to therapy?
   □ No □ Yes

2. Has the patient had an office visit or telephone visit with neurologist within the past 12 months?
   □ No □ Yes

7 – Provider Sign-Off

Additional Information

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**

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