



## PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

# Sabril (vigabatrin)

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
	<b>Supervising Physician:</b>	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. What diagnosis is this drug being prescribed for? <input type="checkbox"/> Epileptic condition <input type="checkbox"/> Infantile spasms <input type="checkbox"/> Other (Please Specify)
Q2. Please provide ICD code(s) for diagnosis.
Q3. Is prescriber a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. For treatment of an epileptic condition, is Sabril being used for seizures refractory to COMBINATION therapy with at least TWO other anticonvulsants? (please list all other antiepileptic agents the patient has used) <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. For treatment of infantile spasms, is the patient between the age of 1 month to 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. For the treatment of infantile spasms, does the prescriber feel the benefits outweigh the potential risk of vision loss in this patient population?



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<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Additional Comments	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

☐ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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