

# US Family Health Plan

## Prior Authorization Request Form for topiramate ER (**Qudexy XR, Trokendi XR**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:  
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

**Step 1 Please complete patient and physician information** (please print):

<b>1</b> Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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**Step 2 Please complete the clinical assessment:**

<b>1. Which medication is being requested?</b>	<input type="checkbox"/> Trokendi XR – proceed to 3 <input type="checkbox"/> Qudexy XR, Topiramate ER – proceed to 2
<b>2. What is the indication or diagnosis?</b>	<input type="checkbox"/> Initial monotherapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 10 years of age and older – proceed to question <b>4</b> <input type="checkbox"/> Adjunctive therapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 2 years of age and older – proceed to question <b>4</b> <input type="checkbox"/> Lennox-Gastaut seizure in a patient 2 years of age and older – proceed to question <b>4</b> <input type="checkbox"/> Migraine prophylaxis in adults – proceed to question <b>4</b> <input type="checkbox"/> All other non-FDA approved indications (for example, weight loss) – <b>STOP - Coverage not approved</b>
<b>3. What is the indication or diagnosis?</b>	<input type="checkbox"/> Initial monotherapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 10 years of age and older – proceed to question <b>4</b> <input type="checkbox"/> Adjunctive therapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 6 years of age and older – proceed to question <b>4</b> <input type="checkbox"/> Lennox-Gastaut seizure in a patient 6 years of age and older – proceed to question <b>4</b> <input type="checkbox"/> Migraine prophylaxis in adults – proceed to question <b>4</b> <input type="checkbox"/> All other non-FDA approved indications (for example, weight loss) – <b>STOP - Coverage not approved</b>

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4. Has the patient tried topiramate immediate-release (IR) and experienced an inadequate response?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 5
5. Has the patient experienced an adverse reaction to a component of the generic topiramate IR that is not expected to occur with the requested agent?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 6
6. Does the patient have a contraindication to a component of generic topiramate IR that is not expected to exist with the requested agent?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

**Step** I certify the above is true to the best of my knowledge. Please sign and date:

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

\_\_\_\_\_  
Date

[09 August 2017]