USFHP Prior Authorization Request Form for topiramate oral solution **(Eprontia)**

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 855-273-5735

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization is not required for patients less than 12 years of age.

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

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication prescribed by or in consultation with an adult or pediatric neurologist?		☐ Yes **Proceed to Question 2**	☐ No **STOP Coverage not approved**
2. What is the indication or diagnosis?	☐ For epilepsy monotherapy: partial onset seizure or primary generalized tonic-clonic seizures in patients 2 years or age or older - **Proceed to Question 3** ☐ For epilepsy adjunctive therapy: partial onset seizure or primary generalized tonic-clonic seizures or seizures associated with Lennox Gastaut syndrome in patients 2 years of age or older - **Proceed to Question 3** ☐ For migraine: preventive treatment in patients 12 years of age or older - **Proceed to Question 3** ☐ Other - **STOP Coverage not approved**		
3. Does the patient require a liquid formulation due to swallowing difficulty or has a feeding tube and cannot use topiramate (sprinkles)?		☐ Yes **Sign and date below**	☐ No **STOP Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

Prescriber Signature _____ Date _____

[11 May 2022]