US Family Health Plan
Prior Authorization Request Form for
Lacosamide ER (Motpoly 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 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**

Prior authorization does not expire.

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. Please explain why the patient requires the requested medication and cannot take the generic formulary alternative, lacosamide tablet.	_____ Proceed to question **2**	
2. **What is the indication or diagnosis?**	☐ Partial-onset seizures - Proceed to question **3** ☐ ther - **STOP** **Coverage not approved**	
3. **Does the patient weigh at least 50 kilograms?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. **Is the requested medication prescribed by a neurologist?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **Is the provider aware of the warnings, screening, and monitoring precautions for the requested medication?**	☐ 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

[28 August 2024]