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

Clinical documentation may be required for approval.
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:

Question		
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**

Question	Options
2. What is the indication or diagnosis?	☐ Initial monotherapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 6 years of age and older – proceed to question **3**
	☐ Adjunctive therapy of partial onset seizure, primary generalized tonic-clonic seizure, or seizures associated with Lennox-Gastaut Syndrome in a patient 6 years of age and older – proceed to question **3**
	☐ Preventive treatment of migraine in patients 12 years of age and older – proceed to question **3**
	☐ All other non-FDA approved indications (for example, weight loss) – **STOP - Coverage not approved**

Question		
3. Has the patient tried topiramate immediate-release (IR) and experienced an inadequate response?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. 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?	☐ Yes **Sign and date below**	☐ No Proceed to question **5**
5. Does the patient have a contraindication to a component of generic topiramate IR that is not expected to exist with the requested agent?	☐ 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