



Fax Completed Form To
1.833.404.2392

Prescriber Help Desk
1.833.587.2012

Online

[covermy meds.com/main/
prior-authorization-forms/](http://covermy meds.com/main/prior-authorization-forms/)

Request for Prior Authorization

Select Anticonvulsants

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis: _____

Patient weight (kg): _____ Date obtained: _____

Is prescriber a neurologist?

Yes No If no, note consultation with neurologist:

Consultation date: _____ Physician name & phone: _____

Document an adequate trial and inadequate response with at least two concomitant AEDs:

Trial #1 drug name and dose: _____

Trial dates: _____ Failure reason: _____

Trial #2 drug name and dose: _____

Trial dates: _____ Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.