OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Aptiom®, Briviact®, Fycompa®, Vimpat® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ Partial-onset seizure
- ❑ Primary generalized tonic-clonic seizures [for **Fycompa** only]
- ❑ Other diagnosis: ______________________________ ICD-10 Code(s): ______________________________

Select the medications the patient has had history of greater than or equal to a 8 week trial of (any release formulation qualifies):
- ❑ Carbamazepine
- ❑ Divalproex
- ❑ Gabapentin
- ❑ Lamotrigine
- ❑ Levetiracetam
- ❑ Lyrica
- ❑ Oxcarbazepine
- ❑ Phenytoin
- ❑ Topiramate
- ❑ Valproic acid
- ❑ Zonisamide
- ❑ Other anticonvulsant(s):____

Clinical Information:
Is the requested medication being used for continuation of prior therapy for a seizure disorder? ❑ **Yes** ❑ **No**
Does the patient have a documented history of persisting seizures after titration to the highest tolerated dose with each medication trial? ❑ **Yes** ❑ **No**
Has lack of compliance as a reason for treatment failure been ruled out? ❑ **Yes** ❑ **No**
Is there documentation of failure due to intolerable side effects? ❑ **Yes** ❑ **No**
Were reasonable efforts made to minimize the side effects (e.g., change timing of dosing, divide dose out for more frequent but smaller doses, etc.)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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