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

Trileptal® & Zonegran® Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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 seizure

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a history of greater than or equal to 4 week trial of the therapeutically equivalent generic? ❑ **Yes** ❑ **No**

Does the patient have a documented history of an inadequate response to the therapeutically equivalent generic as evidenced by one of the following: Change in seizure frequency from baseline, breakthrough seizures not explained by medication noncompliance or significant provoking factor, or status epilepticus? ❑ **Yes** ❑ **No**

Does the patient have a documented history of intolerance to the therapeutically equivalent generic which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., change timing of dosing, divide daily dose out for more frequent but smaller doses)? ❑ **Yes** ❑ **No**

Has the Food and Drug Administration (FDA) been notified of the adverse effects/lack of effectiveness associated with the therapeutically equivalent generic through the FDA Adverse Event Reporting System (FAERS)? ❑ **Yes** ❑ **No**

Will medical records documenting the adverse effect/inadequate response to the therapeutically equivalent generic be submitted to *OptumRx*® with this form? ❑ **Yes** ❑ **No**

***Please note: Chart documentation of the above is required to be submitted along with this fax*

Does the patient have a documented history of drug-resistant epilepsy defined as the failure of two tolerated and appropriately chosen and used anti-epileptic drug schedules (as either mono-therapy or combination therapy) to achieve sustained seizure freedom? ❑ **Yes** ❑ **No**

Does the patient have a documented history of high risk of seizure recurrence defined as one or more of the following: Identifiable brain disease, mental retardation, abnormal neurologic examination, seizure onset after the first decade, multiple seizure types, poor initial response to treatment, juvenile myoclonic epilepsy, epileptiform discharges on electroencephalogram (EEG), family history of epilepsy, hippocampal atrophy or abnormal hippocampal signal on magnetic resonance imaging (MRI)? ❑ **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?

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.