



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit [go.covermymeds.com/OptumRx](http://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

## Trokendi XR® 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:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)
<p><b>Continuation of therapy:</b> Is this for a continuation of prior therapy within the past 120 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Partial onset seizures</p> <p><input type="checkbox"/> Primary generalized tonic-clonic seizures</p> <p><input type="checkbox"/> Prophylaxis of migraine headache</p> <p><input type="checkbox"/> Lennox-Gastaut syndrome (adjunct therapy)</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p><b>Select the medications the patient has a failure, contraindication, or intolerance to:</b></p> <p><input type="checkbox"/> Topamax</p> <p><input type="checkbox"/> Topamax Sprinkle</p> <p><input type="checkbox"/> Topiramate extended-release (ER)</p> <p><input type="checkbox"/> Topiramate Sprinkle</p> <p><input type="checkbox"/> Topiramate tablet</p>
<p><b>Quantity limit requests:</b> What is the quantity requested per DAY? _____</p> <p><b>What is the reason for exceeding the plan limitations?</b></p> <p><input type="checkbox"/> Titration or loading-dose purposes</p> <p><input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)</p> <p><input type="checkbox"/> Requested strength/dose is not commercially available</p> <p><input type="checkbox"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. <b>Please specify:</b> _____</p> <p><input type="checkbox"/> Other: _____</p>

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. If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555. 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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