HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

TOPIRAMATE ER SPRINKLE CAPSULES

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ topiramate extended-release capsules

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
EPILEPSY			
1. Is the member ≥ 2 years of age?	☐	☐	
2. Is the prescribing physician a neurologist or neuro-oncologist?	☐	☐	
3. Does the member have a diagnosis of partial-onset, primary generalized tonic-clonic seizures or seizures associated with Lennox-Gastaut Syndrome?	☐	☐	**Please provide documentation**
4. Has the member tried and failed at least 2 preferred-generic anticonvulsants?	☐	☐	**Please provide documentation**
5. Has the member tried and found to be intolerant to the inactive ingredients in the immediate release topiramate tablets or topiramate sprinkle capsules? If available, at least two generic manufactures must be tried.	☐	☐	**Please provide documentation**
MIGRAINE PREVENTION			
1. Is the member 12 years of age or older?	☐	☐	
2. Is the prescribing provider a neurologist or headache specialist?	☐	☐	
3. Has the member been diagnosed with episodic OR chronic migraines?	☐	☐	**Please provide documentation**
4. Is the member experiencing moderate to severe migraines that is causing him/her functional impairment (e.g. missed school/work, decreased ability to perform daily activity, etc.)?	☐	☐	**Please provide documentation**
5. Has the possibility of rebound headaches or medication overuse headaches* been considered and discussed?	☐	☐	**Please provide documentation**

*Medications associated with rebound or overuse headaches include: narcotics, caffeine, NSAIDs, and triptans.			
6. Has the member tried and found to be intolerant to the inactive ingredients in the immediate release topiramate tablets or topiramate sprinkle capsules? If available, at least two generic manufactures must be tried.	☐	☐	**Please provide documentation**
7. Has the member tried at least 3 of the following for at least 3 months each with an inadequate outcome: • Beta blocker • Calcium channel blocker • Antidepressants • Anticonvulsants • ACE inhibitors/ARBs	☐	☐	**Please provide documentation**
8. Has the member received at least 2 injections of Botox® at least 12 weeks apart?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. For epilepsy, does updated documentation show a positive response to therapy?	☐	☐	**Please provide documentation**
3. For migraine prevention, does updated documentation show a positive response to therapy, defined as a ≥ 50% reduction in headache frequency and/or ≥ 50% reduction in intensity as seen by a decreased need for acute treatment, missed days of school/work, or increase in ability to perform daily activities?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP- 074
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024