Excellus

Sabril®
Rx Benefit

Drug Prior Authorization FAX Form

Complete form and fax to:

Pharmacy Help Desk
Fax #: 1-800-956-2397
Phone #: 1-800-363-4658

Specialty medications can be filled at:

Accredo Health
Fax #: 1-888-773-7386
Phone #: 1-866-413-4137

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:
Location of Infusion: ☐ **Prescriber office** ☐ **Home/Homecare agency:**_____ ☐ **Outpatient facility:** ☐ **Other:** _____	
Servicing Prescriber NPI (if different from the ordering prescriber):	
Provide address for medication shipping (if applicable):	

Medication/Medical and Dispensing Information

1. Check the drug(s) which apply to this request.

	Medication (HCPCS)	Dose	Directions	Height	Weight (lbs./kgs)	Procedure Code
☐	Sabril Tablets		Oral Solution			
☐	Sabril Oral Solution		Tablets			

2. Diagnosis/ICD-10 Code:

3. Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (recertification)? Start Date: _____

Questions/Indications for Medical Necessity

**** See the CRPA Rx Policy (Pharmacy-09) for full Prior Authorization criteria ****

1. Is the patient followed by a ☐ Neurologist ☐ Other	☐ Yes ☐ No
2. Does the patient have a diagnosis of the following? ☐ Infantile Spasm ☐ Refractory Complex Partial Seizure ☐ Other: _____	☐ Yes ☐ No
3. Is the patient between the ages of 1 month and two (2) years of age? (Age: ___ months ____ years)	☐ Yes ☐ No
4. Has the patient had a trial of at least 3 of the following? (Check all which apply) ☐ carbamazepine ☐ sodium valproate ☐ Other ☐ lamotrigine ☐ oxcarbazepine	☐ Yes ☐ No

Provide any other comments/clinical justification:

***ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.**

***Prescriber Signature:** _____ **Date:** _____

I certify the above is true and accurate to the best of my knowledge.