Please complete ALL information below and fax your request to 1-888-671-5285

Oxtellar 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:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Continuation of therapy:

Is this for a continuation of prior therapy with Oxtellar XR? ❑ **Yes** ❑ **No**

Select the diagnosis below:

❑ Partial seizures (adjunctive therapy)

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

Medication history:

Has the patient had a trial and failure or intolerance to generic oxcarbazepine immediate-release (IR)? ❑ **Yes** ❑ **No**

Has the patient had a contraindication to generic oxcarbazepine immediate-release (IR)? ❑ **Yes** ❑ **No**

Select the medications the patient has a trial and failure, contraindication, or intolerance to:

❑ Carbamazepine

❑ Lamotrigine

❑ Levetiracetam

❑ Topiramate

❑ Other generic anticonvulsant(s). Please specify: _____

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.