



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:
<input type="checkbox"/> Check if generic substitution is acceptable	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 with Oxtellar XR? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Select the diagnosis below:</b>  <input type="checkbox"/> Partial seizures (adjunctive therapy)  <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p><b>Medication history:</b>  Has the patient had a trial and failure or intolerance to generic oxcarbazepine immediate-release (IR)? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has the patient had a contraindication to generic oxcarbazepine immediate-release (IR)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Select the medications the patient has a trial and failure, contraindication, or intolerance to:</b>  <input type="checkbox"/> Carbamazepine  <input type="checkbox"/> Lamotrigine  <input type="checkbox"/> Levetiracetam  <input type="checkbox"/> Topiramate  <input type="checkbox"/> Other generic anticonvulsant(s). Please specify: _____</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?

\_\_\_\_\_

\_\_\_\_\_

Please note: This request may be denied unless all required information is received.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.  
Office use only: OxtellarXR\_FSP\_2019Aug-W