



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

Keppra® injection Prior Authorization Request Form

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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)

Select the diagnosis below:

Myoclonic seizures in patients with juvenile myoclonic epilepsy

Partial onset seizures

Primary generalized tonic-clonic seizures

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

Medication history:
 Has the patient had an inadequate response to or inability to tolerate levetiracetam? Yes No

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.

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