Prior Authorization Request Form for Perampanel (Fycompa Oral Suspension)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Note: Prior authorization criteria applies for patients who are older than 18 years. Those younger than 18 years old, do not need to fill out the Prior Authorization in order to fill a perampanel oral solution prescription.

Step 2 **Please complete the clinical assessment:**

1. Is the patient unable to swallow perampanel tablets?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Does the patient has a diagnosis of epilepsy with partial-onset seizures with or without secondarily generalized seizures?	☐ Yes **Sign and date below**	☐ No Proceed to question 3
3. Does the patient has a diagnosis of epilepsy with primary generalized tonic-clonic seizures?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[14 February 2018]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: