topiramate ER (Trokendi XR)

JOHNS HOPKINS
HEALTH PLANS

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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.

Prior Authorization does not expire.

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

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

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

Question		
1. Is the requested medication prescribed by or in consultation with an adult or pediatric neurologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What is the indication or diagnosis?	☐ Initial monotherapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 6 years of age and older – proceed to question **3** ☐ Adjunctive therapy of partial onset seizure, primary generalized tonic-clonic seizure, or seizures associated with Lennox-Gastaut Syndrome in a patient 6 years of age and older – proceed to question **3** ☐ Preventive treatment of migraine in patients 12 years of age and older – proceed to question **3** ☐ All other non-FDA approved indications (for example, weight loss) – **STOP - Coverage not approved**	
3. Has the patient tried topiramate immediate-release (IR) and experienced an inadequate response?	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. Has the patient experienced an adverse reaction to a component of the generic topiramate IR that is not expected to occur with the requested agent?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Does the patient have a contraindication to a component of generic topiramate IR that is not expected to exist with the requested agent?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Which medication is being requested?	☐ Trokendi XR - **Sign and date below** ☐ Topiramate ER capsules (generic Trokendi XR) – proceed to question **7**	

7. **Does the provider acknowledge that brand Trokendi ER is DoD's preferred product over generic topiramate ER and is covered at the lowest (generic) copayment? Note that PA still applies to Trokendi ER brand; no PA is required for generic topiramate sprinkle capsules (generic Topamax Sprinkle).**	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. **Please provide a patient-specific justification as to why brand Trokendi XR cannot be used in this patient.**	**Sign and date below**	

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

_______________________________ Prescriber Signature

_____________ Date

[03 January 2024]

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