Prior Authorization Request Form for
topiramate ER **(Qudexy XR, Trokendi XR)**

JOHNS HOPKINS
MEDICINE
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USFHP Pharmacy Prior Authorization Form

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

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 #:

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

1. Which medication is being requested?	☐ Trokendi XR – proceed to 3 ☐ Qudexy XR, Topiramate ER – proceed to 2
2. What is the indication or diagnosis?	☐ Initial monotherapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 10 years of age and older – proceed to question **4**
	☐ Adjunctive therapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 2 years of age and older – proceed to question **4**
	☐ Lennox-Gastaut seizure in a patient 2 years of age and olde r – proceed to question **4**
	☐ Migraine prophylaxis in adults – proceed to question **4**
	☐ All other non-FDA approved indications (for example, weight loss) – **STOP - Coverage not approved**
3. What is the indication or diagnosis?	☐ Initial monotherapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 10 years of age and older – proceed to question **4**
	☐ Adjunctive therapy of partial onset seizure or primary generalized tonic-clonic seizure in a patient 6 years of age and older – proceed to question **4**
	☐ Lennox-Gastaut seizure in a patient 6 years of age and olde r – proceed to question **4**
	☐ Migraine prophylaxis in adults – proceed to question **4**
	☐ All other non-FDA approved indications (for example, weight loss) – **STOP - Coverage not approved**

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4. Has the patient tried topiramate immediate-release (IR) and experienced an inadequate response?	☐ Yes Sign and date below	☐ No Proceed to question 5
5. 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 Sign and date below	☐ No Proceed to question 6
6. Does the patient have a contraindication to a component of generic topiramate IR that is not expected to exist with the requested agent?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3

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

_____ _____
Prescriber Signature Date

[09 August 2017]

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