

Prescriber Criteria Form

Briviact 2024 PA Fax 4558-A v3 010124.docx
 Briviact (brivaracetam)
 Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
 Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
 Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
 When conditions are met, we will authorize the coverage of Briviact (brivaracetam).

Drug Name:
 Briviact (brivaracetam)

Patient Name:		
Patient ID:		
Patient DOB:	Patient Phone:	
Prescriber Name:		
Prescriber Address:		
City:	State:	Zip:
Prescriber Phone:	Prescriber Fax:	
Diagnosis:	ICD Code(s):	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of partial-onset seizures (i.e., focal-onset seizures) in a patient 1 month of age or older? [If no, then no further questions.]	Yes	No
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to a generic anticonvulsant? [If no, then no further questions.]	Yes	No
3	Is the patient 18 years of age or older? [If no, then skip to question 5.]	Yes	No
4	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to any of the following: A) Aptiom, B) Xcopri, C) Spritam? [No further questions.]	Yes	No
5	Is the patient 4 years of age or older? [If no, then no further questions.]	Yes	No
6	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to any of the following: A) Aptiom, B) Spritam?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:** _____