Prescriber Criteria Form Eprontia 2024 PA Fax 5286-A v2 010124.docx Eprontia (topiramate oral solution) 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 Eprontia (topiramate oral solution).

Drug Name: Eprontia (topiramate oral solution)

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 2 years of age or older? [If no, then skip to question 5.]	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 4 years of age or older? [If no, then no further questions.]	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 requested drug being prescribed as adjunctive therapy for the treatment of primary generalized tonic-clonic seizures in a patient 2 years of age or older? [If no, then skip to question 9.]	Yes	No
6	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

7	Is the patient 6 years of age or older? [If no, then no further questions.]	Yes	No
8	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to Spritam? [No further questions.]	Yes	No
9	Is the requested drug being prescribed as monotherapy for the treatment of primary generalized tonic-clonic seizures in a patient 2 years of age or older? [If yes, then skip to question 12.]	Yes	No
10	Is the requested drug being prescribed as adjunctive therapy for the treatment of seizures associated with Lennox-Gastaut syndrome in a patient 2 years of age or older? [If yes, then no further questions.]	Yes	No
11	Is the requested drug being prescribed for the preventative treatment of migraines in a patient 12 years of age or older? [If no, then no further questions.]	Yes	No
12	Has the patient experienced an inadequate treatment response or intolerance to topiramate tablets or capsules? [If yes, then no further questions.]	Yes	No
13	Does the patient have difficulty swallowing solid oral dosage forms (e.g., tablets, capsules)?	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:**_____