BlueCross BlueShield Federal Employee Program

# TOPIRAMATE POWDER PRIOR APPROVAL REQUEST

**Send completed form to:**
**Service Benefit Plan**
**Prior Approval**
**P.O. Box 52080 MC 139**
**Phoenix, AZ 85072-2080**
**Attn. Clinical Services**
**Fax: 1-877-378-4727**

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

| **Patient Information (required)** | | | **Provider Information (required)** | | |
|---|---|---|---|---|---|
| Date: | | | Provider Name: | | |
| Patient Name: | | | Specialty: | NPI: | |
| Date of Birth: | Sex: ❑Male ❑Female | | Office Phone: | Office Fax: | |
| Street Address: | | | Office Street Address: | | |
| City: | State: | Zip: | City: | State: | Zip: |
| Patient ID: **R** | | | Physician Signature: | | |
| **PHYSICIAN COMPLETES** | | | | | |

## Topiramate Powder

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

**NOTE**: Form must be completed in its **entirety** for processing

1. Which dosage form will the Topiramate powder be compounded into? ***Please select dosage form below:***
   ❑Oral (capsule/suspension/tablet) ❑Topical (cream/gel/ointment/patch/solution)
   ❑Other dosage form ***(please specify)***: _____

2. Has the patient tried and failed and/or had an intolerance to an existing commercially available oral formulation? ❑Yes ❑No

3. Will the final product exceed the FDA approved limits of 200mg per dose? ❑Yes* ❑No
   ***If YES***, please specify: _____

4. What is the patient's diagnosis?
   ❑Epilepsy / epileptic seizures
      a. Are all of the active ingredients in the compound prescription only products and FDA approved for epilepsy/epileptic seizures? ❑Yes ❑No
   ❑Migraine headache
      a. Are all of the active ingredients in the compound prescription only products and FDA approved for migraine headaches? ❑Yes ❑No
      b. Is the medication being used for migraine headache prophylaxis? ❑Yes ❑No
      c. Is this **INITIATION** of therapy? ❑Yes* ❑No
         ***If YES***, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to alternative treatments? ❑Yes ❑No
   ❑Other diagnosis ***(please specify)***: _____

 