Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Anticonvulsant Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Keppra. PA is required for Gabitril, Neurontin, and Topamax for members older than 18 years. Information about anticonvulsants can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information: Section I

Anticonvulsant request
(Check one or all that apply)
- ☐ Gabitril (tiagabine)
- ☐ Keppra (levetiracetam)
- ☐ Neurontin (gabapentin)
- ☐ Topamax (topiramate)

Dose, frequency, and duration of requested drug

Drug NDC (if known) or service code

Indication for anticonvulsant requested (Check one or all that apply.)

☐ Seizure disorder
Type: _____
☐ Postherpetic neuralgia (gabapentin only)
☐ Other (describe): _____

Please list all other medications currently prescribed for the member for this indication.

_____

_____

Is member currently hospitalized for this condition? ☐ Yes ☐ No

Has member ever been hospitalized for this condition? ☐ Yes. Dates of most recent hospitalization: _____
☐ No

Is member under the care of a neurologist? ☐ Yes ☐ No

Is member under the care of a psychiatrist? ☐ Yes ☐ No

Name of neurologist and/or psychiatrist: _____ Telephone no.: _____

Date of last visit with neurologist and/or psychiatrist: _____

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Medication information: Section II

Please complete this section if indication is NOT for a seizure disorder. (This section does not need to be completed if indication is for a seizure disorder.)

Has member tried other medications for this condition?

☐ Yes. Complete box A.

☐ No. Explain why not. _____

A. Drug name

Dates of use | Dose and frequency

Briefly describe details of adverse reaction, inadequate response, intolerance, or other.

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Has member previously tried requested anticonvulsant?

☐ Yes. Complete box B.

☐ No. Explain why not. _____

B. Drug name

Dates and length of use | Maximum daily dose

Briefly describe how member responded to the requested anticonvulsant.

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date