



Sabril [vigabatrin, Vigadrone] Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____
Request Initiated For: _____

- What is the prescribed product?

<input type="checkbox"/> Sabril 500mg powder	<input type="checkbox"/> vigabatrin 500mg powder
<input type="checkbox"/> Sabril 500mg tablets	<input type="checkbox"/> vigabatrin 500mg tablets
<input type="checkbox"/> Vigadrone 500mg powder	<input type="checkbox"/> Other _____
- What is the diagnosis?
 - Infantile spasms
 - Complex partial seizures (CPS)
 - Other _____
- What is the ICD-10 code? _____
- The preferred products for your patient's health plan are vigabatrin 500mg powder, vigabatrin 500mg tablets and Vigadrone 500mg powder. Can the patient's treatment be switched to a preferred product?
If Yes, fax a new prescription to the pharmacy and skip to #8.
 - Yes - vigabatrin 500mg powder
 - Yes - vigabatrin 500mg tablets
 - Yes - Vigadrone 500mg powder
 - No - Continue request for brand Sabril
 - Not applicable - brand Sabril is not being requested, *skip to #8*
- Has the patient failed treatment with the generic medication due to an intolerable adverse event (e.g., rash, nausea, vomiting)? Yes No
- Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)? Yes No
- Was this documented in the patient's chart? ***ACTION REQUIRED: Documentation is required for approval. Provide SPECIFIC and DETAILED chart documentation including description, date/time, and severity of the adverse event, dosage and duration of generic medication treatment, required intervention (if any), and relevant tests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.*** Yes No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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8. Is the patient currently receiving therapy with the requested medication?
 Yes No *If No, skip to #10 (if applicable)*
9. Has the patient shown substantial clinical benefit from vigabatrin therapy? Yes No *No further questions*

Complete the following questions if patient has complex partial seizures (CPS).

10. How many alternative treatments for complex partial seizures (CPS) has the patient tried and had an inadequate response to? *Indicate number of alternative treatments:* _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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