Sabril® (vigabatrin)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #: Fax #:
Member DOB:	Tax ID or NPI Number:

If Applicable: Pharmacy Name: ______________________________
Pharmacy Phone: ______________________________

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ Complex Partial Seizures (CPS) ☐ Infantile Spasms (IS)	
Physician Specialty	☐ Neurologist ☐ Other (please specify): ______________________	
Clinical Consideration	***In order to mitigate risk, clinical benefit must be documented and vision testing must be performed regularly. If criteria are met, initial approval for refractory CPS will be three months (one month for IS). Continued approval will be granted at 6 month increments.*** Is this the FIRST course of therapy? ☐ Yes (go to "INITIAL REQUESTS") ☐ No (go to "CONTINUED THERAPY")	
INITIAL REQUESTS: ***Complex Partial Seizures***	Patient has had documented failure of at least two (2) other anticonvulsant agents: Medication 1/ date: ____________________ Medication 2/ date: ____________________	
	Has the patient had baseline vision testing? ☐ Yes ☐ No	Is the patient ≥ 18 years old? ☐ Yes ☐ No
INITIAL REQUESTS: ***Infantile Spasms***	Has the risk of vision loss with Sabril been weighed against the benefits of other potential therapies? ☐ Yes ☐ No	
	Has the patient had baseline vision testing? ☐ Yes ☐ No	Is the patient between the ages of 1 month and 2 years old? ☐ Yes ☐ No
CONTINUED THERAPY: ***Both indications***	Has substantial clinical benefit been documented? (***must supply office notes***): ☐ Yes ☐ No	
	Has the patient had vision testing at least every 3 months? ☐ Yes ☐ No	
Supporting Documentation	Diagnosis: ICD-9/10 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Sabril® (vigabatrin) Strength ______________________ Sig ______________________ Qty ______________________ Refills	
	Please attach all relevant medical records and test results **We will not process incomplete forms.** **If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.**	

Confidentiality Notice:

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options.

STEP 3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete. (please sign and date)

________________________________ ________________________

Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Name of Person filling out form: ____

Pharmacy Technician initials ______ Date Initiated _________________