

Prescriber Criteria Form

Fycompa 2024 PA Fax 4557-A v2 010124.docx  
 Fycompa (perampanel)  
 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 Fycompa (perampanel).

Drug Name:  
 Fycompa (perampanel)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

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 4 years of age or older with epilepsy? [If no, then skip to question 3.]	Yes	No
2	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? [If yes, then skip to question 5.] [If no, then no further questions.]	Yes	No
3	Is the requested drug being prescribed as adjunctive therapy for the treatment of primary generalized tonic-clonic seizures in a patient 12 years of age or older with epilepsy? [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 Spritam? [If no, then no further questions.]	Yes	No
5	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to a generic anticonvulsant?	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:** \_\_\_\_\_