

**Physician's Prior Authorization Questionnaire
Sabril®**

Patient:

ID#:

DOB:

Patient Address:

Sabril® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(No codes please)* _____
2. Is the patient between the age of one month and two years? Yes No

If this is for initiation of coverage, please answer questions 3 through 5. If this is for continuation, please answer questions 6 and 7.

Initiation:

3. Has the caregiver been informed of the potential for visual adverse effects? Yes No
4. Has the patient's vision been assessed for a baseline measurement? Yes No
5. What is the dose (mg/kg/day) that is being requested? _____

Continuation:

6. Has the patient demonstrated a substantial clinical benefit from an initial trial of Sabril? Yes No
7. What is the dose (mg/kg/day) that is being requested? _____

Sabril® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx