

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

Patient:

ID#:

DOB:

Patient Address:

Vimpat® 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. Does the patient have a diagnosis of Partial-Onset Seizures? Yes No

If No, what is the diagnosis? _____

2. Is Vimpat® being used as initial treatment? Yes No

3. Has the patient experienced inadequate seizure control while on at least one other seizure medication?
 Yes No

4. Will Vimpat® be used in combination with any other seizure medication? Yes No

5. Does the patient require more than two tablets per day? Yes No

If Yes, please explain why and for how long: _____

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