

**Community Care of Wake & Johnston Counties
MD Easy™ Form – Anticonvulsants**

This form MUST BE FAXED to the PHARMACY

Practice Information		Patient Information	
Practice Name		Patient Name	
Practice Address		Patient Address	
Practice City, State, Zip		Patient City, State, Zip	
Practice Phone	Practice Fax	Date of Birth	Medicaid ID
Pharmacy Information		Originally Prescribed Anticonvulsant	
Pharmacy Name		Drug Name/Strength	
Pharmacy Phone	Pharmacy Fax	Last Filled	Quantity

Anticonvulsant Prior Authorization Criteria

Criteria for coverage of Lyrica

- Patient has diagnosis of seizure disorder
- Patient has diagnosis of Neuropathic pain AND has a documented failure with a 60 day trial of at least 2 of the following agents in the past 12 months: 1) a tricyclic antidepressant 2) gabapentin 3) carbamazepine 4) valproic acid OR has documented adverse reaction or contraindications that precludes trial of 1) a tricyclic antidepressant 2) gabapentin 3) carbamazepine 4) valproic acid
- Patient has diagnosis of Fibromyalgia AND has a documented failure with a 60 day trial of at least 2 of the following agents in the past 12 months: an antidepressant (TCA, doxepin, SSRI, SNRI), cyclobenzaprine, or gabapentin OR has documented allergy or contraindications that precludes trial of 2 of the following agents: 1) antidepressants 2) cyclobenzaprine, 3) gabapentin
- Patient has diagnosis of anxiety disorder AND has a documented failure with a 60 day trial of a Selective Serotonin Reuptake Inhibitor (SSRI) in the past 12 months OR has a documented adverse reaction or contraindication that precludes trial of SSRI.

Criteria for coverage of Topamax

- Patient has diagnosis of seizure disorder
- Patient has diagnosis of Migraine headache AND has a documented failure with a 60 day trial of a minimum of two of the following agents in the past 12 months: 1) B-blockers, 2) tricyclic antidepressants, 3) divalproex or valproic acid 4) calcium channel blockers, or 5) gabapentin OR has documented adverse reaction or contraindication that precludes trial of two of the following agents 1) B-blockers, 2) tricyclic antidepressants, 3) divalproex or valproic acid 4) calcium channel blockers, and 5) gabapentin

Criteria for coverage of Trileptal

- Patient has diagnosis of seizure disorder
- Patient has diagnosis of Trigeminal neuralgia AND has a documented failure with a 60 day trial of carbamazepine in the past 12 months OR has a documented adverse reaction or contraindication that precludes trial of carbamazepine

Criteria for coverage of Lamictal

- Patient has diagnosis of seizure disorder
- Patients has a diagnosis of Bipolar Disorder I or II Depressive or Maintenance Phase

Procedures

1. Length of therapy may be approved for up to 12 months.
2. Changes in strength will not require additional prior authorization.
3. Exemption Forms will not be accepted for this drug class.
4. PAs can be submitted for patients who meet the above criteria by phoning ACS at 866-246-8505 or by faxing a PA request form (located at www.ncmedicaidpbm.com) to ACS at 866-246-8507. No PA request will be accepted prior to December 8, 2009.

Please select from the following options:

****Attention Pharmacists****

*Please discontinue originally prescribed medication listed above and change patient to the option selected below.
If the patient does not immediately need this prescription, please keep it on file for the next refill.*

- | | | |
|--|---|---|
| <input type="checkbox"/> Topiramate 25 mg | <input type="checkbox"/> Lamotrigine 25 mg | <input type="checkbox"/> Oxcarbazepine 150 mg |
| <input type="checkbox"/> Topiramate 50 mg | <input type="checkbox"/> Lamotrigine 100 mg | <input type="checkbox"/> Oxcarbazepine 300 mg |
| <input type="checkbox"/> Topiramate 100 mg | <input type="checkbox"/> Lamotrigine 150 mg | <input type="checkbox"/> Oxcarbazepine 600 mg |
| <input type="checkbox"/> Topiramate 200 mg | <input type="checkbox"/> Lamotrigine 200 mg | |

Directions: _____

Dispense #: _____ Refill#: _____

Prescriber Signature: _____ Date: _____

Prescriber Name (please print): _____ DEA/NPI: _____

Note: By signing this document & checking the substitution above, you are consenting to this being a legal prescription & the pharmacy should fill it as such.