Prescriber Criteria Form

Fycompa 2025 PA Fax 4557-A v1 010125.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)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

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:_____