Prescriber Criteria Form

Vigabatrin 2025 PA Fax 548-A v2 010125.docx
Sabril, Vigadrone, Vigpoder (vigabatrin), Vigabatrin
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 Vigabatrin.

Drug Name (select from list of drugs shown):

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	Does the patient have a diagnosis of infantile spasms? [If no, then skip to question 3.]	Yes	No
2	Is the patient 1 month to 2 years of age? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of complex partial seizures (i.e., focal impaired awareness seizures)? [If no, then no further questions.]	Yes	No
4	Has the patient experienced an inadequate treatment response to at least two antiepileptic drugs for complex partial seizures (i.e., focal impaired awareness seizures)? [If no, then no further questions.]	Yes	No
5	Is the patient 2 years of age or older?	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:____________________