



**Kansas Medical Assistance Program**

P O Box 3571  
Topeka, KS 66601-3571  
Provider 1-800-933-6593  
Beneficiary 1-800-766-9012

**Prior Authorization for Non-Preferred Adjunct Antiepileptics**

*Clinical prior authorization may apply*

| Preferred   | Non-Preferred, Prior Authorization Required   |
|---|---|
| Keppra® (levetiracetam)<br>Keppra® XR (levetiracetam XR)<br>Lyrica® (pregabalin)<br>Neurontin® (gabapentin)<br>Zonegran® (zonisamide) | Banzel® (rufinamide)<br>Briviact® (brivaracetam)<br>Fycompa® (perampanel)<br>Gabitril® (tiagabine)<br>Onfi® (clobazam)<br>Oxtellar XR® (oxcarbazepine)<br>Potiga® (ezogabine) |

**Beneficiary Information**

Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Pharmacy Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Requested Drug: \_\_\_\_\_ NDC: \_\_\_\_\_

**Prescriber Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Please check the appropriate box and provide required information to receive the requested non-preferred drug.

**Patient has a medical intolerance to preferred drug.** Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: \_\_\_\_\_

**Patient has had an inadequate response to preferred drug.** Name of preferred agent patient tried: \_\_\_\_\_

**An appropriate formulation or indication is not available as a preferred drug.** Please specify which formulation or indication is needed and information supporting the need: \_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.  
This form will be returned unprocessed if it is not completed in its entirety.