TRICARE Prior Authorization Request Form for
lacosamide ER **(Motpoly XR)**

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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. What is the indication or diagnosis?	☐ Partial-onset seizures - Proceed to question **2** ☐ Other - **STOP Coverage not approved**	
2. Does the patient weigh at least 50 kilograms?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by a neurologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the provider aware of the warnings, screening, and monitoring precautions for the requested medication?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Please explain why the patient requires the requested medication and cannot take the generic formulary alternative, lacosamide tablet.	_____ **Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[8 May 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: