

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

SABRIL (vigabatrin)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992 note the new fax number**

CRITERIA:

- Minimum age requirement: 16 years old.
- Documented failure of other therapy.
- Uncontrolled complex partial seizures.
- Documented enrollment of both prescriber and patient in the SHARE program.
- Negative pregnancy test for women of childbearing age.

OR

- Age between one month and two years old.
- Diagnosis of infantile spasms.
- Documented enrollment of both prescriber and patient in the SHARE program.

AUTHORIZATION:

The initial prior authorization will be approved for six months to assess safety and efficacy in the individual patient.

RE-AUTHORIZATION:

Subsequent prior authorizations will be given in one year increments, upon submission of a letter of medical necessity

04/19/11

<http://health.utah.gov/medicaid/pharmacy>