Office use only: Reviewed by: ____________________

Review date: ______________ Approved Denied

## Prior Authorization Form

# TOPAMAX® (topiramate)

ONLY COMPLETED FORMS WILL BE REVEIWED

Dosage: ____________

Date: ______________________

Patient Name: ____________________________ DOB: ____________________

Insurance ID #: ___________________________ Office Contact: _____________

Prescribing Physician: _______________________ Office Phone: _____________

Provider Specialty: _________________________ Office Fax: ________________

1. **Must meet one of the following criteria (please check)**:

☐ Treatment of seizure disorder

☐ Preventative therapy for hard to treat headaches

☐ Treatment of neuropathic pain

☐ Mood stabilization or treatment of bipolar disorder after failure of carbamaepine, divalproex, and lamotrigine.

**Please attach any supporting clinical information that may be useful in the review of this prior authorization.**

**Health Plan Select does not cover medications prescribed for weight loss or weight control.**

**Fax completed form to (706) 549-8004. Your office will receive a response via fax.**