Mountain Pacific
INNOVATING BETTER HEALTH

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Montana Healthcare Programs Prior Authorization Request Form for Use of Motpoly XR® (lacosamide)

Member Name:	DOB:	Date:
Member ID:	Requested Dose:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Prescriber Phone:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member has a diagnosis of partial-onset seizures: ☐ Yes ☐ No
2. Member has a weight of 50kg or greater: ☐ Yes ☐ No Current weight: _____
3. Member has tried lacosamide immediate-release and has a clinically compelling reason the extended-release product is necessary: ☐ Yes ☐ No

   Rationale for extended-release product: _____

   _____

   _____
4. Provider has documented baseline seizure activity to show improvement upon transition from IR to XR lacosamide: ☐ Yes ☐ No
5. Provider attests that if discontinuation of Motpoly® XR is appropriate, there will be a gradual dose reduction over at least a week: ☐ Yes ☐ No

LIMITATIONS:

Maximum dose for initial authorization: 400mg daily

Initial authorization will be issued for 6 months.

☐ CONTINUATION OF THERAPY

Member has had documentation of positive clinical response to therapy compared to lacosamide IR (reduction in the frequency and/or severity of symptoms and exacerbations): ☐ Yes ☐ No

LIMITATIONS:

Maximum dose for renewal authorization: 400mg daily

Reauthorization will be issued for 12 months.

Please complete form, including required attachments, and fax to Medicaid Drug Prior Authorization Unit at 1-800-294-1350.