

Onfi[®] Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)			
Member Name:			Provider Name:			
Insurance ID#:			NPI#:	I#: Specialty:		
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
City:	State:	Zip:	Office Street Address:			
Phone:			City:	State:		Zip:
Medication Information (required)						
Medication Name:			Strength:	Dosage Form:		orm:
Check if requesting brand			Directions for Use:			
Check if request is f						
Clinical Information (required)						
 Select the diagnosis below: Intractable treatment-resistant seizure disorder Seizures associated with Lennox-Gastaut syndrome (LGS) Other diagnosis: ICD-10 Code(s): 						
Prescriber specialty:						
Is Onfi prescribed by or in consultation with a neurologist? I Yes I No						

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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