



RxAmerica  
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Minnesota Health Care Programs Prior Authorization Request Form  
 Banzel® (rufinamide)

● ● ● Only one medication request per form ● ● ● All fields must be complete and legible for review ● ● ●

<input type="checkbox"/> STANDARD REVIEW (72 HOURS)		<input type="checkbox"/> EXPEDITED REVIEW (24 HOURS)	
By selecting the expedited review and signing this form below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.			
<b>PATIENT INFORMATION</b>		<b>PRESCRIBER INFORMATION</b>	
Patient Name:		Prescriber Name and Specialty:	
Member ID#:		DEA #:	
Sex (circle): Male      Female		Office Phone:	
Date of Birth:		Office Fax:	
Patient Phone:		Contact Person:	
<b>PHARMACY INFORMATION</b>			
Pharmacy Name:	NABP#:	PHARMACY PHONE NO:	PHARMACY FAX NO:
<b>DIAGNOSIS AND MEDICAL INFORMATION</b>			
Medication:	Strength and Route of Administration:	Frequency:	
<input type="checkbox"/> New Prescription – OR – Date Therapy Initiated:      /      /	Expected Length of Therapy:	Quantity:	
Height & Weight:	Drug Allergies:	Diagnosis Related to Medication Requested:	
<b>Rationale for Prior Authorization Request</b>			
Medical Justification for Banzel			
1. Does the patient have a current diagnosis of Lennox-Gastuat syndrome?			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
2. Has the patient had an inadequate response to one or more of the following medications?			
felbamate <input type="checkbox"/> YES <input type="checkbox"/> NO			
lamotrigine <input type="checkbox"/> YES <input type="checkbox"/> NO			
topiramate <input type="checkbox"/> YES <input type="checkbox"/> NO			
Prescriber's Signature:		Date:	