Sabril (Vigabatrin)  
Prior Authorization Form

START HERE

<table>
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<tr>
<th>Member &amp; Prescriber Information</th>
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<tbody>
<tr>
<td>Member Name:</td>
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<td>Prescriber Name:</td>
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<th>Criteria</th>
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<tbody>
<tr>
<td>Sabril is approvable for Infantile Spasms.</td>
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<tr>
<td>All other conditions require the use of four or more current formulary alternatives as listed.</td>
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<td>Approval duration is 12 months and resubmission required for longer therapy.</td>
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<td>Copies of SHARE program registration materials required to accompany prior authorization requests.</td>
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Check appropriate box below and include medical record note and copies of completed SHARE registration materials.

- **Infantile Spasms**  
  - Age of spasm onset: ________________________________  
  - Duration of vigabatrin therapy: _____________________

- **Check current & prior therapies used** (must have tried 4 or more agents)

  - Carbamazepine
  - Lamotrigine
  - Divalproex
  - Levetiracetam
  - Ethosuximide
  - Oxcarbazepine
  - Felbamate (Felbatol)
  - Phenytoin
  - Valproic acid
  - Zonisamide
  - Topiramate
  - Gabapentin
  - Pregabalin (Lyrica)
  - Other:

Additional information:

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

☐ **Vigabatrin** 500 mg tablet  
☐ **Vigabatrin** 500 mg powder pack

- Starting dose: ____________________________________________  
- Target dose: _____________________________________________  
- Quantity needed per 30-day supply: _________________________

Prescriber Signature: ___________________________ Date: ____________

Mailing Address
Physicians Plus Insurance Corporation  
Attn: Pharmacy Services  
P.O. Box 2078  
Madison WI  53701-2078  

Physicians Plus Pharmacy Services Fax: (608) 327-0324
Prior Authorization Questions?  
(608) 260-7803 or (800) 545-5015  
www.pplusic.com/providers