

VIGABATRIN ENROLLMENT FORM

Date: _____ Needs by Date: _____

Ships to: Patient Home (address given under Patient Information) Other: _____

1 PATIENT INFORMATION

(Please complete the following or send patient demographic sheet)

Patient Name (First, MI, Last): _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Patient Phone (Home): _____
 Alternate Phone: _____
 Language Preferred: English Spanish Other _____
 DOB: _____ Gender: Male Female
 Allergies: _____

2 PRESCRIBER INFORMATION

(Please complete the following information)

Prescriber's Name: _____
 Practice Name: _____
 State Lic#: _____
 NPI #: _____ TaxID#: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____ Phone: _____

3 INSURANCE INFORMATION

(Please copy and attach the front and back of insurance and prescription drug card)

4 STATEMENT OF MEDICAL NECESSITY

ICD-10-CM Diagnosis Code

G40.2: Localization-related symptomatic epilepsy & epileptic syndromes with complex partial seizures
G40.82: Epileptic Spasms (Infantile)
 Other: _____

Other Clinical Information

Current frequency of monthly refractory complex partial seizures or infantile spasms:

Previous and/or Current Seizure Treatments

	Treatment Name	Dose	Start Date	Stop Date	Current	Intolerant
<input type="checkbox"/>	Phenytoin	_____	_____	_____	_____	_____
<input type="checkbox"/>	Clonazepam	_____	_____	_____	_____	_____
<input type="checkbox"/>	Levetiracetam	_____	_____	_____	_____	_____
<input type="checkbox"/>	Steroids	_____	_____	_____	_____	_____
<input type="checkbox"/>	Valproate	_____	_____	_____	_____	_____
<input type="checkbox"/>	Other	_____	_____	_____	_____	_____
<input type="checkbox"/>	Other	_____	_____	_____	_____	_____
<input type="checkbox"/>	Other	_____	_____	_____	_____	_____

**** (Please copy and attach a comprehensive medication list to allow screening for potential drug-to-drug interactions)****

Vigabatrin Prescribing Information Suggested Dosing:

- For Adults (17 years of age and older): Treatment should be initiated at 1000 mg/day (500 mg twice daily). Total daily dose may be increased in 500-mg increments at weekly intervals, depending on response. The recommended dose of vigabatrin in adults is 3000 mg/day (1500 mg twice daily).
- For Patients 2 to 16 years of age: Treatment for patients weighing 10 kg to 60 kg should be initiated based on body weight, administered as two divided doses, and may be increased in weekly intervals to the total daily maintenance dosage, depending on response (see PI for full details). Patients weighing more than 60 kg should be dosed according to adult recommendations.
- For Infants (1 month to 2 years of age): The initial daily dosing is 50 mg/kg/day given in 2 divided doses (25 mg/kg twice daily); subsequent dosing can be titrated by 25-mg/kg/day to 50-mg/kg/day increments every 3 days, up to a maximum of 150 mg/kg/day given in 2 divided doses (75 mg/kg twice daily).

5 PRESCRIPTION INFORMATION

Vigabatrin 500-mg tablets

Qty: _____ Days Supply: _____ Patient Weight (kg): _____ Date Weighed: _____

Sig: _____ Refills: _____

X _____ X _____
 PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.