Epilepsy Medication Program Application

APPLICANT INFORMATION – PLEASE PRINT

Name: _____ _____ _____
Last First Client I.D. Male or Female

Mailing Address: _____ _____ _____
(Must be a street address) Telephone Date of Birth

_____ _____ _____ _____
City County State Zip

I am presently living in Florida. _____ Yes _____ No

I have epilepsy and require medication. (Prescription attached.) _____ Yes _____ No

I do not have Medicaid or health insurance that covers epilepsy medication, or I have an insurance co-pay or deductible I cannot afford. _____ Yes _____ No

My annual net family income is $_____

There are _____people in my family.

My assets, other than my homestead, are below $2,500. _____ Yes _____ No

MEDICAL INFORMATION

Do you have any known allergies/drug reactions? _____ Yes _____No
If yes, please name the drug(s):

_____

List prescription medication you are now taking which were not received from Central Pharmacy:

_____

List Over-the-Counter medication you are now taking:

_____

Please check if you have any of the health conditions listed below:

_____Arthritis
_____Ulcers
_____Diabetes
_____Cancer
_____Epilepsy
_____Asthma
_____Heart Conditions
_____Kidney Disease
_____Lung Disease
_____Rheumatic Fever
_____Tuberculosis
_____Liver Disease
_____Blood Clotting Disorders
_____High Blood Pressure
_____Parkinson's Disease
_____Anemia
_____Pregnancy
_____Other _____

I acknowledge that all information provided by me is true to the best of my knowledge. I understand if I have a change in income or assets, I must report that change to the county health department (CHD) within 90 days of that change. I understand that the CHD may verify the income information I provide. I understand that any intentional false or misleading statement by me can be charged as a second degree misdemeanor and will result in my loss of eligibility for this program.

Please mail my prescription to: ____ my home address above or _____ the CHD at _____

_____ _____ _____
Applicant Signature **Date**

ELIGIBILITY DETERMINATION: TO BE COMPLETED BY CHD – CHECK THE APPLICABLE BOX BELOW

I certify that based on the information provided by the applicant and according to Technical Assistance Guideline, Chronic 12, this applicant

☐ is eligible for the Epilepsy Medication Program.

☐ is eligible for the Epilepsy Medication Program as a current client with an annual net family income at 101% to 200% of the Federal poverty guidelines, that meets all of the other eligibility criteria, has no resources to purchase epilepsy medication and no other source can be found for his/her epilepsy medication. This client shall be charged a fee for the epilepsy medication based on a sliding fee scale as set forth in Chapter 64F-16, F.A.C.

☐ is not eligible for the Epilepsy Medication Program.

_____	_____	_____
Signature of CHD Employee	Date of Eligibility Determination	Date of Eligibility Expiration (one year from determination date)

EMERGENCY ISSUANCE: TO BE COMPLETED BY CHD

This applicant is not eligible for the Epilepsy Service Program but has declared that he/she does not have the resources to purchase epilepsy medication. No other source can be found for his/her epilepsy medication; therefore this applicant is eligible to receive a one-month emergency supply of epilepsy medication at no cost, one time within a 12-month period.

_____	_____
Signature of CHD Employee	Date

REFERRAL TO THE EPILEPSY SERVICE PROGRAM

CHD staff are encouraged to use the opportunity presented while determining eligibility for the epilepsy medication program to ask the client if he/she has signed up for the Epilepsy Service Program (ESP). If the client is not an ESP client, CHD staff should provide the client with information on the Epilepsy Service Program that is available in the county. This information can be obtained on the second page of this form.

INSTRUCTIONS TO COMPLETE THE EPILEPSY MEDICATION PROGRAM APPLICATION FORM

APPLICANT INFORMATION: Assist the applicant in completing the information in this section. It may be necessary to read or explain this section to the applicant.

A prescription that includes the following information must be attached to this form:

- Person's name (printed or typed)
- Person's date of birth
- Practitioner's state license number and DEA number if applicable
- Practitioner's name (printed or typed)
- Practitioner's signature
- Practitioner's phone number
- Date of prescription
- Type of epilesy medication (must be on the Department formulary) see list on page to of this form
- Medication dosage
- Whether and how many refills are allowed

ELIGIBILITY CRITERIA: Determine the applicant's eligibility based on the criteria below:

- Is a self-declared resident of Florida.
- Has epilepsy
- Is uninsured, lacking insurance that covers epilepsy medication, or has an insurance deductible or copay that the applicant cannot afford.
- Has a net family income at or below 100% of the poverty guidelines.
- Has no more than $2,500 in private funds, bank accounts, or assets other than a homestead.
- Is not a current Medicaid recipient.

The CHD will determine eligibility in accordance with their written procedures. The CHD may require documentation of income or accept self-declaration as documentation in accordance with local policy. Self-declaration of Florida residency, insurance status, and assets is acceptable.

If the CHD has an on-site pharmacy, the CHD will retain the original application form.

If the CHD does not have an on-site pharmacy, send the original application and prescription to:

Central Pharmacy
116-A Hamilton Park Drive
Tallahassee, FL 32304
(850) 922-9036 or (800) 554-4584

Epilepsy Service Program Providers

Epilepsy Services of West Central Florida
3811 W Sligh Avenue
Tampa, Florida 33614
813-870-3414
Service Area: Hardee, Highlands, Hillsborough, and Polk

Epilepsy Association of the Big Bend
1302 E. Sixth Ave.
Tallahassee, Florida 32303
850-222-1777
Service Area: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington.

Epilepsy Services of South West Florida
1750 17th Street, Building I-2
Sarasota, Florida 34234
941-953-5988
Service Area: Charlotte, Collier, Desoto, Glades, Hendry, Lee, Manatee, and Sarasota

Epilepsy Foundation of Florida
1200 N.W. 78th Avenue
Miami Florida 33126
305-670-4949
Service Area: Alachua, Baker, Bradford, Broward, Citrus, Clay, Columbia, Dade, Dixie, Duval, Escambia, Flagler, Gilchrist, Hamilton, Hernando, Indian River, Lafayette, Lake, Levy, Marion, Martin, Monroe, Nassau, Okaloosa, Okeechobee, Palm Beach, Putnam, Santa Rosa, St. Lucie, St. Johns, Sumter, Suwannee, Union, Volusia, and Walton

Epilepsy Association of Central Florida
109 North Kirkman Road
Orlando Florida, 32811
407-422-1416
Service Area: Brevard, Orange, Osceola, and Seminole

Suncoast Epilepsy Association
5700 54th Avenue North
St Petersburg Florida 33709
727-546-2856
Service Area: Pasco, Pinellas

Epilepsy Medication Formulary
Important! Please use the following units of issue:
AcetaZOLAMIDE tablet 250mg
CarBAMazepine (Carbatrol) capsule, extended release 200mg
CarBAMazepine (Carbatrol) capsule, extended release 300mg
ClonazePAM (KlonoPin) tablet 0.5mg
ClonazePAM (KlonoPin) tablet 1mg
ClonazePAM (KlonoPin) tablet 2mg
Divalproex (Depakote) sodium delayed release tablet 125mg
Divalproex(Depakote) sodium delayed release tablet 500mg
Ethosuximide capsule 250mg
Ethosuximide syrup 250mg/5ml
Gabapentin capsule 400mg
Gabapentin tablet 100mg
Gabapentin tablet 300mg
LamoTRIgine tablet 25mg
LamoTRIgine tablet 100mg
LamoTRIgine tablet 150mg
LamoTRIgine tablet 200mg
LevETIRAcetam solution 100mg/mL
LevETIRAcetam tablet 500mg
LevETIRAcetam tablet 750mg
LevETIRAcetam tablet 1000mg
LORazepam tablet 0.5mg
LORazepam tablet 1 mg
LORazepam tablet 2 mg
Oxcarbazepine tablet 150 mg
Oxcarbazepine tablet 300 mg
Oxcarbazepine tablet 600 mg
PHENobarbital tablet 15 mg
PHENobarbital tablet 30 mg
PHENobarbital tablet 100 mg
Phenytoin capsule, extended release 30 mg
Phenytoin capsule, extended release 100 mg
Phenytoin suspension 25 mg/mL
Phenytoin tablet, chewable 50 mg
Pregabalin capsule 25 mg
Pregabalin capsule 50 mg
Pregabalin capsule 100 mg
Pregabalin capsule 200 mg
Primidone suspension 250 mg/5 mL
Primidone tablet 50 mg
Primidone tablet 250 mg
TiaGABine tablet 4 mg
TiaGABine tablet 12 mg
TiaGABine tablet 16 mg
Topiramate tablet 25 mg
Topiramate tablet 50 mg
Topiramate tablet 200 mg
Zonisamide capsule 25 mg
Zonisamide capsule 50 mg
Zonisamide capsule 100 mg