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**

DH 2007-CHP-10/2014

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
1215 Lee Avenue
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
1900 Main Street, Suite 212
Sarasota, Florida 34236
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 250mg tablet, 100/btl. (Diamox)
Ativan (lorazepam) 0.5mg 100/btl
Ativan (lorazepam) 1mg 100/btl
Ativan (lorazepam) 2mg 100/btl
Carbamazepine 100mg chewable and 200mg tablet, 100/btl.
CARBATROL CAPS 200MG/120 BTL
CARBATROL CAPS 300MG/120 BTL
***Clonazepam 0.5mg, 2mg tablet, 100/btl. (Klonopin)DEPAKOTE ER TABS. 500MG/100BTL**
DEPAKOTE SPRINKLE 125MG/ 100BTL
Divalproex Sodium 125mg, 250mg, 500mg tablet, 100/btl. (Depakote)
Ethosuximide syrup, 250 mg/5ml, 16 oz. btl. (Zarontin)
Gabapentin 100mg capsule, 100/btl. (Neurontin)
Gabapentin 300mg capsule, 100/btl. (Neurontin)
GABAPENTIN 400MG/100 BTL CAPS
GABAPENTIN 600MG/100 BTL CAPS
GABAPENTIN 800MG/100 BTL CAPS
Gabitril 12mg/100btl tabs(Tiagabine)
Gabitril 16mg/100btl tabs(Tiagabine)
Gabitril 4mg/100btl tabs(Tiagabine)
KEPPRA ORAL SOLUTION 100MG/ML
KEPPRA TABS 1000MG/60 BTL
KEPPRA TABS 500MG/120 BTL
KEPPRA TABS 750MG/120 BTL
Klonopin 0.5 mg (Clonazepam) 100/btl
Klonopin 1.0 mg (Clonazepam) 100/btl
Klonopin 2.0 mg (Clonazepam) 100/btl
LAMICTAL TABLETS 150MG bottle 60/bottle
LAMICTAL TABLETS 200MG 60/bottle
Lamotrigine 25mg, 100mg tablet, 100/btl. (Lamictal)
Lyrica (Pregabalin) 100mg
Lyrica (Pregabalin) 200mg
Lyrica (Pregabalin) 25mg
Lyrica (Pregabalin) 50mg
***Phenobarbital 100mg (1 1/2gr.) tablet, 100/btl.**
Phenobarbital 15mg 1000/btl
Phenobarbital 30mg 1000/btl
Phenytoin (Dilantin) 30mg 100/btl
Phenytoin (Dilantin) 50mg 100/btl
Phenytoin (Dilantin) Suspension
PHENYTOIN 100MG
Primidone (Mysoline) 250mg 100/btl
Primidone (Mysoline) 50mg 100/btl
Primidone Suspension bottle
Topamax 200mg (Topiramate)
Topamax 25mg (Topiramate)
Topamax 50mg (Topiramate)
TRILEPTAL TABS. 150MG/100BTL
TRILEPTAL TABS. 300MG/100BTL
TRILEPTAL TABS. 600MG/100BTL
ZARONTIN (ETHOSUXIMIDE) 250MG
ZONEGRAM CAPS.(ZONISAMIDE 100MG/100BTL
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