Prior Authorization Request Form for Anticonvulsant

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

For a Seizure Disorder: Requests for a non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to **two (2)** preferred Anticonvulsants? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.* **Therapeutic failure of preferred Anticonvulsants must include the generic equivalent when the generic equivalent is designated as preferred**	*Medications Taken Previously (start and end date and dose):* ☐ Yes _____ ☐ No _____
For Other Diagnoses: Requests for non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Anticonvulsants approved or medically accepted for member's diagnosis? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.* **Therapeutic failure of preferred Anticonvulsants must include the generic equivalent when the generic equivalent is designatedas preferred**	☐ Yes ☐ No *Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

☐ Member has a current history (within past 90 days) of using the prescribed the requested non-preferred anticonvulsant, since:_____

☐ If requesting for daily quantity exceeding daily limit (Refer to _____ https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information: _____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

REQUEST FOR CLONAZEPAM WITH CONCURRENT BUPRENORPHINE AGENT FOR OPIOID USE DISORDER:

☐ The prescriptions were prescribed by the same prescriber
☐ The prescriptions were prescribed by different prescribers
☐ All prescribers are aware of the other prescription
☐ Has an **acute** need for clonazepam-specify:_____

REQUEST FOR CLONAZEPAM WITH ANOTHER BENZODIAZEPINE:

☐ Member is being titrated or tapered from another benzodiazepine
☐ Medical reason for concomitant use of benzodiazepines supported by national treatment guidelines or peer-reviewed medical literature. Supporting evidence:_____

REQUEST FOR CLONAZEPAM WITH 2 OR MORE PAID CLAIMS FOR ANY BENZODIAZEPINE:

- ☐ The prescriptions were prescribed by the same prescriber
- ☐ The prescriptions were prescribed by different prescribers
- ☐ All prescribers are aware of the other benzodiazepine prescription
- ☐ The multiple prescriptions are consistent with medically accepted prescribing practices and standard of care, supported by peer-reviewed medical literature or national treatment guidelines. Supporting evidence:_____

REQUEST FOR CLONAZEPAM FOR MEMBER UNDER 21 YEARS OF AGE:

- ☐ Member has one of the following diagnosis – specify all that apply:
  - ☐ Seizure Disorder
  - ☐ Chemotherapy-Induced Nausea/Vomiting
  - ☐ Cerebral Palsy
  - ☐ Spastic Disorder
  - ☐ Dystonia
  - ☐ Catatonia
  - ☐ Receiving Palliative Care

RENEWAL REQUESTS:

- ☐ Documentation of tolerability and experienced a positive clinical response to requested medication evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)