



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.covermyeds.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:
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IV. REQUIRED DOCUMENTATION (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: _____

<p>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.</p> <p>Therapeutic failure of preferred Anticonvulsants must include the generic equivalent when the generic equivalent is designated as preferred</p>	<p>Medications Taken Previously (start and end date and dose): _____</p> <p><input type="checkbox"/> Yes _____</p> <p><input type="checkbox"/> No _____</p>
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<p>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.</p> <p>Therapeutic failure of preferred Anticonvulsants must include the generic equivalent when the generic equivalent is designated as preferred</p>	<p><input type="checkbox"/> Yes Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.</p> <p><input type="checkbox"/> No</p>
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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.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx>), 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 :

Empty box for providing additional rationale or clinical information.

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