# 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 [redacted] |
| **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 [redacted] |

- ☐ 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: [redacted]

**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: [redacted]

**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.)