Prior Authorization Request Form for Anxiolytics/Benzodiazepine

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: _____

Did the prescriber or prescriber's delegate search the PDMP to review the member's controlled substance prescription history before issuing this prescription for the requested agent?	☐ Yes ☐ No
Is the member taking a benzodiazepine with another controlled substance? *(NOTE: Concomitant benzodiazepine/opioid use will not be approved, unless the benzodiazepine or opioid is being tapered or concomitant use is determined to be medically necessary)*	☐ Yes ☐ No Medical justification for concomitant use: [redacted]
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Benzodiazepines? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No Medication Taken Previously (start and end date and dose): [redacted]

CHECK ALL THAT APPLY. *SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.*

Therapeutic Duplication:

- ☐ Member is taking **2 or more different** benzodiazepines concurrently
  - ☐ Concomitant use of benzodiazepines is supported by national treatment guidelines or medical literature: [redacted]
  - ☐ Is being titrated to or tapered from one of the benzodiazepines
- ☐ Member has filled **2 or more prescriptions for any** benzodiazepine in the past 30 days
  - ☐ The prescriptions are for the same benzodiazepine, strength and directions
    - ☐ Each prescription was filled for < 30 days' supply
    - ☐ Other reason for filling >1 benzodiazepine prescription in the past 30 days –specify:_____
  - ☐ 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:

Exceeds Quantity Limit:

■ 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:[redacted]

MEMBER IS UNDER 21 YEARS OF AGE:

- ☐ Member has one of the following diagnosis – specify all that apply:
  - ☐ Seizure Disorder
  - ☐ Chemo-Induced Nausea/Vomiting
  - ☐ Cerebral Palsy
  - ☐ Spastic Disorder
  - ☐ Dystonia
  - ☐ Catatonia
  - ☐ Receiving Palliative Care
  - ☐ Does not have one of the above diagnosis and is not receiving palliative care
    - ☐ Use is supported for <21 years old by national treatment guidelines or medical literature
    - ☐ Member has tried other treatments for their condition:_____

MEMBER IS CONCURRENTLY ON ANOTHER CONTROLLED SUBSTANCE (INCLUDING BUPRENORPHINE):

- ☐ 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
- ☐ Has an **acute** need for the request benzodiazepine-specify:_____

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.)