





Fax Completed Form To 1.833.404.2392

Prescriber Help Desk 1.833.587.2012

Online

covermymeds.com/main/ prior-authorization-forms/

Select Anticonvulsants (PLEASE PRINT – ACCURACY IS IMPORTANT)

Request for Prior Authorization

IA Medicaid Member ID #	Patient name	DOB		
Patient address				
Provider NPI	Prescriber name	Phone		
Prescriber address Fax				
Pharmacy name	Address	Phone		
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.				
Pharmacy NPI	Pharmacy fax NDC			

Prior authorization (PA) is required for select anticonvulsants. Payment will be considered under the following conditions:

- I) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
- 2) Patient has an FDA approved or compendia indicated diagnosis, for requested drug, of seizures associated with Lennox- Gastaut syndrome, Dravet syndrome, tuberous sclerosis complex, or cyclindependent kinase-like 5 (CDKL5) deficiency disorder with documentation of an adequate trial and inadequate response with at least two preferred concomitant antiepileptic drugs (AEDs), if available; and
- 3) Is prescribed by or in consultation with a neurologist; and
- 4) Patient's current weight is provided; and
- 5) The total daily dose does not exceed the following:
 - a. Fenfluramine
 - i. With concomitant stiripentol (plus clobazam): 0.4 mg/kg/day with a maximum of 17 mg per day: or
 - ii. Without concomitant stiripentol: 0.7 mg/kg/day with a maximum of 26 mg per day; or
 - b. Stiripentol
 - i. Prescribed concomitantly with clobazam: and
 - ii. 50 mg/kg/day with a maximum of 3,000 mg per day; or
 - c. Ganaxolone
 - i. Weight ≤ 28 kg: 63 mg/kg/day; or
 - ii. Weight > 28 kg: 1800 mg/day.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferreu				
Diacomit	Fintepla	Ztalmy		
Strength		Dosage Instructions	Quantity	Days Supply

Non Droforrod

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Diagnosis:	· · · · · · · · · · · · · · · · · · ·	prior-authorization-forms/
Patient weight (kg):	Date obtained:	
ls prescriber a neur	ologist?	
🗌 Yes 🗌 No	If no, note consultation with neurologist:	
Consultation date:	Physician name & phone:	
Document an adequ	ate trial and inadequate response with at least two concomitant	AEDs:
Trial #1 drug name a	nd dose:	
Trial dates:	Failure reason:	
Trial #2 drug name a	nd dose:	
	Failure reason:	
Medical or contraindi	cation reason to override trial requirements:	

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.