Diacomit

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

ICD-10 Code: _____
Prescribed Drug and Dosage Form: _____
Is a loading dose required: ❑ Yes ❑ No
Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

1. What is the diagnosis?
   ❑ Seizures associated with Dravet syndrome
   ❑ Other _____
2. *If the patient is 6 months of age or older*, will the requested drug be taken with clobazam and another anti-seizure medication concurrently? ❑ Yes ❑ No ❑ N/A - patient is less than 6 months age
3. Is the request for continuation of therapy with Diacomit? ❑ Yes ❑ No *If No, no further questions.*
4. Has the patient achieved and maintained positive clinical response as evidenced by reduction in frequency or duration of seizures compared with seizure activity prior to initiating Diacomit? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

***X*_____**
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155