CAREFIRST
Valtoco

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Valtoco.

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (specify drug)

_____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1. Is the requested drug being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from the patient's usual seizure pattern in a patient with epilepsy? **Y** ☐ **N** ☐

2. Which drug is being requested? [Please check the drug being requested.]

   Libervant (diazepam buccal film) (If checked, go to 5) ☐

   Valtoco (diazepam nasal spray) (If checked, go to 3) ☐

3. Is the patient 2 years of age or older? **Y** ☐ **N** ☐

4. Does the patient require MORE than the plan allowance of 10 blister packs per month? [Coverage is provided up to an amount sufficient for treating up to five episodes per month at the maximum dose of the requested drug.] **Y** ☐ **N** ☐

5. Is the patient 2 to 5 years of age? **Y** ☐ **N** ☐

6. Does the patient require MORE than the plan allowance of 10 individual pouches (5 cartons) per month? [Coverage is provided up to an amount sufficient for treating up to five episodes per month at the maximum dose of the requested drug.] **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.