PA Request Criteria

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195449

CAREFIRST ASO
Nayzilam

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 Nayzilam.

Patient Name: _____ **Date:** 11/27/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)
Nayzilam (midazolam nasal spray)

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. Is the patient 12 years of age or older? **Y** ☐ **N** ☐

3. Does the patient require more than the plan allowance of 10 nasal spray units (5 boxes) per month? **Y** ☐ **N** ☐
   [Note: Coverage is provided up to an amount sufficient for treating up to five episodes per month at the maximum dose of the requested drug.]

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

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