Prior Authorization Form

CAREFIRST - CF FACETS FEP RSK VF

Seizure LGS- Dravet

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-582-2038** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Seizure LGS- Dravet.

Drug Name (select from list of drugs shown)

Banzel (rufinamide)	Clobazam	Onfi (clobazam)
Rufinamide	Sympazan (clobazam)	

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for adjunctive treatment of seizures associated with Lennox-Gastaut syndrome? Y N

[If Yes, then go to 2. If No, then go to 7.]

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

Banzel (rufinamide) (If checked, go to 3) ☐

Onfi (clobazam) (If checked, go to 4) ☐

Sympazan (clobazam) (If checked, go to 4)	☐
3. Is the patient 1 years of age or older?	Y N
[If Yes, then go to 5. If No, then no further questions.]	
4. Is the patient 2 years of age or older?	Y N
[If Yes, then go to 5. If No, then no further questions.]	
5. Is this request for continuation of therapy?	Y N
[If Yes, then go to 6. If No, then no further questions.]	
6. 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 initiation of the requested drug?	Y N
[No further questions.]	
7. Is the requested drug being prescribed for the treatment of seizures associated with Dravet syndrome?	Y N
[If Yes, then go to 8. If No, then no further questions.]	
8. Which drug is being requested? [Please check which drug is being requested.]	
Onfi (clobazam) (If checked, go to 9)	☐
Sympazan (clobazam) (If checked, go to 9)	☐
Other (If checked, no further questions)	☐
9. Is this request for continuation of therapy?	Y N
[If Yes, then go to 10. If No, then no further questions.]	
10. 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 initiation of the requested drug?	Y N
[No further questions.]	

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