BlueCross BlueShield
Federal Employee Program

VALTOCO
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Valtoco

(diazepam nasal spray)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Is this request for brand or generic? ❑Brand ❑Generic
2. Will the patient need more than 10 doses every 30 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ doses every 30 days
3. Does the patient have a diagnosis of intermittent seizure episodes, such as seizure clusters or acute repetitive seizures? ❑Yes ❑No
4. Will this medication be used for acute seizures? ❑Yes ❑No
5. Are the patient's seizure episodes distinct from the patient's usual epilepsy seizure pattern? ❑Yes ❑No
6. Does the prescriber agree to assess the patient before prescribing concomitant opioid therapy to limit opioid dosages and durations to the minimum required? ❑Yes ❑No
7. Is this medication being used for the treatment of anxiety? ❑Yes ❑No
8. Is the patient on a stable regimen of antiepileptic therapy? ❑Yes ❑No
9. Will this medication be used in combination with another Prior Authorization (PA) benzodiazepine? ❑Yes* ❑No
   If YES, please specify the medication: _____
   Benzodiazepine: Libervant (diazepam buccal film), Nayzilam (midazolam)
10. Has the patient been on this medication continuously for the last **2 months** excluding samples? ❑Yes ❑No