



Federal Employee Program.

ZTALMY
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: <input type="checkbox"/> Male <input type="checkbox"/> Female		Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:		State:	Zip:	City:		State: Zip:
Patient ID: R <input type="text"/>				Physician Signature:		
PHYSICIAN COMPLETES						

Ztalmy oral suspension
(ganaxolone)

*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

Is this request for brand or generic? ☐ Brand ☐ Generic

How many bottles will the patient need for a 90 day supply? _____ bottle(s) per 90 days

1. What is the patient's diagnosis?

- ☐ Seizures associated with Cyclin-Dependent Kinase-Like 5 (CDKL5) Deficiency Disorder (CDD)
☐ Other diagnosis (*please specify*): _____

2. Does the prescriber agree to monitor for the emergence or worsening of depression, suicidal thoughts or behavior, or unusual changes in mood or behavior? ☐ Yes ☐ No

3. Does the prescriber agree to decrease the Ztalmy dose gradually when discontinuing treatment? ☐ Yes ☐ No

4. Has the patient been on Ztalmy continuously for the last **6 months**, excluding samples? **Please select answer below:**

☐ **NO** – this is **INITIATION** of therapy, please answer the following questions:

- a. Is there a molecular confirmation of a pathogenic or likely pathogenic mutation in the CDKL5 gene? ☐ Yes ☐ No
b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** antiepileptic drugs (e.g., valproate, levetiracetam, clobazam, vigabatrin, etc)? ☐ Yes ☐ No

☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

- a. Has there been a decrease in the number of seizures from baseline? ☐ Yes ☐ No



**BlueCross
BlueShield**

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA.
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 . Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

faster... easier... better...	Introducing ePA! Online Prior Authorizations in minutes through Caremark.com/ePA . Sign up today!
	CVS/caremark 