

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Select drug below)

Nayzilam[®] (midazolam nasal spray)

Valtoco[®] (diazepam nasal spray)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ Date: _____

Recommended Dosing:

- **Nayzilam[®] nasal spray:** Administer one spray (5 mg dose) into one nostril. Optional second dose after 10 minutes. Maximum dose: 2 doses per episode, 1 episode every 3 days, 5 episodes per month.
- **Valtoco[®] (diazepam) nasal spray:** Initial Dose: 5 mg and 10 mg doses are administered as a single spray intranasally into one nostril. Administration of 15 mg and 20 mg doses requires two nasal spray devices, one spray (7.5 mg or 10 mg) into each nostril. A second dose, when required, maybe administered at least 4 hours after the initial dose. Maximum dose: 2 doses per episode, 1 episode every 5 days, 5 episodes per month.
- **Quantity Limit for Nayzilam and Valtoco:** 10 spray units per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Criteria

(Continued on next page)

- ❑ Member must meet **ONE** of the following age requirements:
 - ❑ If requesting **Nayzilam[®]**, member must be 12 years of age or older
 - ❑ If requesting **Valtoco[®]**, member must be 6 years of age or older

AND

- ❑ Prescribing physician is a neurologist or has consulted with a neurologist

AND

- ❑ Member has a diagnosis of epilepsy

AND

- ❑ Member will be using Nayzilam[®] or Valtoco[®] for the acute treatment of intermittent episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) which are distinct from the member's usual seizure pattern with epilepsy (**chart notes must be submitted for documentation of seizure activity**)

AND

- ❑ Member is currently receiving maintenance antiepileptic medication(s) (e.g., lamotrigine, levetiracetam, topiramate, oxcarbazepine)

AND

- ❑ Prescriber agrees to assess the member before prescribing concomitant opioid therapy to limit opioid dosages and durations to the minimum required

AND

- ❑ Dose does not exceed the FDA-approved maximum dose

AND

- ❑ Nayzilam[®] and Valtoco[®] will **NOT** be used concomitantly

Exclusion Criteria: Patients with known hypersensitivity to midazolam and acute narrow-angle glaucoma

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

Use of samples to initiate therapy does not meet step edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.