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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Diacomit® (stiripentol)

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:** _____

Weight: _____ **Date:** _____

Recommended dosage: 50 mg/kg/day, administered by mouth in 2 or 3 divided doses: Maximum quantity limit is 3000 mg/day.

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.

Initial Authorization: 6 months

- ❑ Medication must be prescribed by or in consultation with a neurologist

AND

- ❑ Member must be 6 months of age or older

AND

- ❑ Member must have a diagnosis of seizures associated with Dravet Syndrome **(must submit chart notes with confirmed diagnosis)**

AND

(Continued on next page)

- ❑ Member must be refractory to an anti-epileptic regimen that includes valproate and clobazam (AEDs) that are appropriate for Dravet Syndrome **(subject to verification through pharmacy paid claims)**

AND

- ❑ Diacomit® must be used as adjunctive therapy with clobazam **(must have pharmacy paid claims)**. There is no clinical data to support the use of Diacomit® as monotherapy in Dravet syndrome

AND

- ❑ Provider attests to reviewing a complete blood count (CBC) prior to initiating treatment with Diacomit® and will monitor periodically throughout therapy

Reauthorization: 12 months. 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.

- ❑ Member must continue to meet initial approval criteria

AND

- ❑ Member has a documented positive clinical response to treatment (defined as: decrease from baseline and stabilization of seizure frequency/severity)

AND

- ❑ Member must be absent of unacceptable toxicity from therapy (i.e., significant weight loss, neutropenia, thrombocytopenia)

Medication being provided by Specialty Pharmacy - PropriumRx

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.****