

Anticonvulsant Prior Authorization (PA) Request Form
CT Medical Assistance Program
To Be Completed By Prescriber

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ()	Patient Current Weight:
Fax ()	Patient Current Height:
	Patient Primary ICD Diagnosis Code:
<u>Prescription Information</u>	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Quantity Requested:

<u>Preferred Agents:</u>	<u>Non-Preferred Agents:</u>	
CARBAMAZEPINE TAB CHEW, IR TAB	APTIOM TABLET	<i>ONFI SUSPENSION, TABLET †</i>
CARBATROL ER CAPSULE*	<i>BANZEL SUSPENSION, TABLET †</i>	OXCARBAZEPINE SUSPENSION
CLOBAZAM SUSPENSION, TABLET	BRIVARACETAM TABLET	OXCARBAZEPINE ER TABLET
CLONAZEPAM IR TABLET	BRIVIACT SOLUTION, TABLET	OXTELLAR XR TABLET
DEPAKOTE SPRINKLE CAPSULE*	CARBAMAZEPINE ER CAP, TAB	PERAMPANEL TABLET
DIAZEPAM RECTAL GEL SYSTEM	CARBAMAZEPINE SUSPENSION	PHENYTEK CAPSULE
DIVALPROEX SOD DR TABLET	CELONTIN CAPSULE	PHENYTOIN SOD EXT CAP
DIVALPROEX SOD ER TABLET	CLONAZEPAM ODT	(200MG, 300MG)
EPIDIOLEX SOLUTION	DEPAKOTE DR, ER TABLET	QUDEXY XR CAPSULE
EPITOL TABLET	<i>DIACOMIT CAPS, POWDER PACK †</i>	<i>RUFINAMIDE SUSP, TABLET †</i>
ETHOSUXIMIDE CAPSULE, SOLUTION	DILANTIN CAPSULE, SUSPENSION	SEZABY VIAL
LACOSAMIDE TABLET, SOLUTION	DILANTIN INFATAB	SPRITAM TABLET
LAMOTRIGINE CHEW DISPERS TAB	DIVALPROEX SPRINKLE CAPSULE	SUBVENITE SUSPENSION
LAMOTRIGINE IR TABLET	ELEPSIA XR TABLET	SUBVENITE TAB START KIT
LEVETIRACETAM SOLUTION, IR TAB	EPRONTIA SOLUTION	SYMPAZAN FILM
NAYZILAM NASAL SPRAY	EQUETRO CAPSULE	TEGRETOL TABLET
OXCARBAZEPINE TABLET	ESLICARBAZEPINE TABLET	TOPAMAX SPRINKLE CAPSULE
PHENOBARBITAL ELIX, SOLUTION, TAB	<i>FELBAMATE SUSPENSION, TAB †</i>	TOPAMAX TABLET
PHENYTOIN CHEW TAB, SUSP	<i>FELBATOL SUSPENSION, TAB †</i>	TOPIRAMATE ER CAPSULE

PHENYTOIN SOD EXT 100 MG CAP	<i>FINTEPLA SOLUTION †</i>	TOPIRAMATE ER SPRINK CAP
PRIMIDONE TABLET	FYCOMPA SUSPENSION, TABLET	TOPIRAMATE SOLUTION
ROWEEPRA TABLET	KEPPRA SOLUTION, TABLET	TRILEPTAL TABLET
SABRIL 500 MG POWDER PACK*	KEPPRA XR TABLET	TROKENDI XR CAPSULE
SABRIL 500 MG TABLET*	KLONOPIN TABLET	VIGABATRIN POWDER PACKET
SUBVENITE TABLET	LACOSAMIDE UNIT DOSE CUP	VIGABATRIN TABLET
TEGRETOL SUSPENSION*	LAMICTAL TABLET	VIGADRONE POWDER PACKET
TEGRETOL XR TABLET*	LAMICTAL DISPER TABLET	VIGADRONE TABLET
TIAGABINE TABLET	LAMICTAL ODT, ODT START KIT	VIGAFYDE SOLUTION
TOPIRAMATE SPRINKLE CAPSULE	LAMICTAL XR START KIT	VIGPODER POWDER PACKET
TOPIRAMATE IR TABLET	LAMICTAL XR TABLET	VIMPAT SOLUTION, TABLET
TRILEPTAL SUSPENSION*	LAMOTRIGINE ER TABLET	VIMPAT STARTER KIT
VALPROIC ACID CAPSULE, SOLUTION	LAMOTRIGINE ODT TABLET	XCOPRI TAB, TITRATION PAK
VALTOCO NASAL SPRAY	LAMOTRIGINE TAB START KIT	XCOPRI DAILY DOSE PACK
ZONISAMIDE CAPSULE	LEVETIRACETAM ER TABLET	ZARONTIN CAP, SOLUTION
	<i>LIBERVANT FILM †</i>	ZONISADE SUSPENSION
	METHSUXIMIDE CAPSULE	<i>ZTALMY SUSPENSION †</i>
	MOTPOLY XR CAPSULE	

***Bold** = Brand Preferred
† *Drug Specific Criteria*

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with neurologist or other specialist in the treated disease state (as appropriate for diagnosis) Please specify subspecialty: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Will requested medication be used as adjunctive therapy with another anticonvulsant agent? If so, please specify other anticonvulsant agent: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the requested agent being used to treat a documented diagnosis of Bipolar Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Patient trialed and failed ONE preferred anti-epileptic agent? NOTE: For Lennox-Gastaut Syndrome (LGS) (e.g., epidiolex, generic clobazam, clonazepam, lamotrigine, topiramate) OR Dravet syndrome (e.g., valproic acid, clobazam, epidiolex) OR documented Contraindication and/or Adverse Drug Event or Adverse Drug Reaction to therapy? <input type="radio"/> Please specify diagnosis: _____ <input type="radio"/> Preferred agent trialed: _____ <input type="radio"/> Trial Dates: _____ <input type="radio"/> Reason for Failure: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> ○ If Adverse Reaction, Adverse Event, or Contraindication, please specify details: <hr/> <hr/>	
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For Initial Approval:
Medication Requested and Documented diagnosis of ONE of the following:
(attach supporting documentation, required)

<p><u>Banzel (rufinamide) (Patients 1+ years):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Lennox-Gastaut Syndrome (LGS) AND • Prescriber attests to ALL the following (provide documentation): <ul style="list-style-type: none"> ○ Banzel is being used as <u>adjunctive therapy only</u> ○ Documented Baseline ECG shows QTc>330 ms ○ No personal or family history of Familial Short QT syndrome (FSQTS) AND • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Diacomit (stiripentol) (6+ months of age and weigh 7+ kg):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Dravet Syndrome AND • Prescriber attests to ALL the following (provide documentation): <ul style="list-style-type: none"> ○ Patient does NOT have a history of moderate to severe hepatic or renal impairment ○ Diacomit is being used as <u>adjunctive therapy only</u> with CLOBAZAM AND • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 3 of the Clinical Information section) <p><i>NOTE: The following dosage limitations apply:</i></p> <ul style="list-style-type: none"> ○ DIACOMIT 250 MG CAPSULE-12 capsules per day ○ DIACOMIT 250 MG POWDER PACKETS-12 packets per day ○ DIACOMIT 500 MG CAPSULE- 6 capsules per day ○ DIACOMIT 500 MG POWDER PACKET- 6 packets per day 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Felbatol (felbamate):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> ○ Partial (Focal) Seizures OR ○ Lennox-Gastaut Syndrome (LGS) as adjunctive therapy only AND 	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 3 of the Clinical Information section) AND Prescriber attests to ALL the following (provide documentation): <ul style="list-style-type: none"> Baseline CBC and LFT's (including AST and ALT) required prior to initiation of therapy (attach lab results or chart notes with results) Patient does NOT have a history of any blood dyscrasias (e.g., aplastic anemia, bone marrow depression) Patient does NOT have a history of hepatic dysfunction or active liver disease The physician acknowledges that the risks of Felbatol use have been provided to the patient, parent, or guardian, and that acknowledgment is documented in the chart notes <p><i>NOTE : Felbamate is NOT indicated as first-line antiepileptic treatment; it is recommended for use only in patients who respond inadequately to alternative treatments and whose epilepsy is so severe that a substantial risk of aplastic anemia and/or liver failure is deemed acceptable in relation to benefits.</i></p>	
<p><u>Fintepla (fenfluramine) (2+ years old):</u></p> <ul style="list-style-type: none"> Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> Lennox-Gastaut Syndrome (LGS) OR Dravet Syndrome AND Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 3 of the Clinical Information section) <p><i>NOTE: The following dosage limitations apply:</i></p> <ul style="list-style-type: none"> <i>With concomitant Diacomit: 17 mg per day</i> <i>Without concomitant Diacomit: 26 mg per day</i> <i>Therapy will deny if the patient has a documented history of monoamine oxidase inhibitor (MAOI) therapy in the last 45 days</i> 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Libervant Buccal Film (diazepam) (2-5 years of age):</u></p> <ul style="list-style-type: none"> Patient requires Acute Treatment of Intermittent Episodes of Frequent Seizure Activity AND Documented medical reason why GENERIC preferred formulation DIASTAT cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Onfi (clobazam):</u></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> • Patient has a documented diagnosis of Lennox-Gastaut Syndrome (LGS) <ul style="list-style-type: none"> ○ ONFI is being used as <u>adjunctive therapy only</u> AND • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 3 of the Clinical Information section) • Documented medical reason preferred CLOBAZAM generic cannot be used: _____ _____ 	
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<p><u>Rufinamide (1+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Lennox-Gastaut Syndrome (LGS) AND • Prescriber attests to ALL the following (provide documentation): <ul style="list-style-type: none"> ○ Rufinamide is being used as <u>adjunctive therapy only</u> ○ Documented Baseline ECG shows QTc>330 ms ○ No personal or family history of Familial Short QT syndrome (FSQTS) AND • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<p><u>Ztalmy (ganaxolone) (2+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Cyclin-dependent Kinase-like 5 (CDKL5) Deficiency Disorder AND • Prescriber attests to completion of required of genetic testing confirming presence of pathogenic or likely pathogenic variant in the Cyclin-dependent Kinase-like 5 (CDKL5) gene (provide documentation) <p><i>NOTE: Claim cannot exceed maximum dosage limitations:</i></p> <ul style="list-style-type: none"> ○ <i>For participants without severe hepatic impairment:</i> <ul style="list-style-type: none"> ▪ <i>Weight ≤ 28 kg: 63 mg/kg/day;</i> ▪ <i>Weight > 28 kg: 1,800 mg/day</i> ○ <i>For participants with severe hepatic impairment</i> <ul style="list-style-type: none"> ▪ <i>Weight ≤ 28 kg: 21 mg/kg/day</i> ▪ <i>Weight > 28 kg: 600 mg/day</i> 	<input type="checkbox"/> Yes <input type="checkbox"/> No
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For ALL Other Non-Preferred Anticonvulsant Medication Requests:

<ul style="list-style-type: none"> • Patient experienced failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent appropriate for the specified indication (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • The requested agent is being used to treat ONE of the following Documented Diagnosis: <ul style="list-style-type: none"> ○ Seizure Disorder ○ Neuropathic Pain ○ Chronic Migraine 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • For Specific Formulation Renewal Requests: <ul style="list-style-type: none"> ○ For Brand Requests when a Therapeutically Equivalent Generic is Preferred: Provider must provide a documented medical reason the preferred generic formulation cannot be used _____ ○ For Generic Requests when a Therapeutically Equivalent Brand is Preferred: Provider must provide a documented medical reason the preferred brand formulation cannot be used _____ ○ For Non-Preferred Dosage or Formulation Requests: Provider must provide a documented medical reason the preferred dosage or formulation cannot be used _____ 	

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

<ul style="list-style-type: none"> • Is the requested agent being used to treat a documented diagnosis of Bipolar Disorder? 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has the patient previously met the required criteria set forth in Section 1 above (Initial Medication Request)?</p> <ul style="list-style-type: none"> • Previous Approved Prior Authorization Number: _____ • Approval Dates: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • Patients' clinical response to treatment and ongoing safety has been documented and monitored 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • Prescriber attests that the patient has a continued need for therapy and patient is compliant with current therapy regimen 	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> • <u>For Felbatol Continuation of Therapy:</u> Documentation required of routine CBC and LFT monitoring as clinically determined, patient continues to have no evidence of blood dyscrasia or hepatic dysfunction 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<ul style="list-style-type: none"> • For Specific Formulation Renewal Requests: <ul style="list-style-type: none"> ○ For Brand Requests when a Therapeutically Equivalent Generic is Preferred: Provider must provide a documented medical reason the preferred generic formulation cannot be used _____ ○ For Generic Requests when a Therapeutically Equivalent Brand is Preferred: Provider must provide a documented medical reason the preferred brand formulation cannot be used _____ ○ For Non-Preferred Dosage or Formulation Requests: Provider must provide a documented medical reason the preferred dosage or formulation cannot be used _____ 	

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission. I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*: _____ **Date:** _____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**

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