OPTIMA HEALTH PLAN

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 1-800-750-9692.** 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: (Select drug below)

❑ **Nayzilam®** (midazolam nasal spray)	❑ **Valtoco®** (diazepam nasal spray)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

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

❑ 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

(Continued on next page)

- ❑ 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.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 1/16/2020
REVISED/UPDATED: ~~2/25/2020; 6/12/2020;~~ **10/4/2022**;