SENTARA HEALTH PLANS

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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Select drug below)

❑ **Libervant™** (diazepam) buccal film	❑ **Nayzilam®** (midazolam nasal spray)	❑ **Valtoco®** (diazepam nasal spray)

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

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosing:

- **Libervant™ (diazepam) buccal films:** Administer 5 mg to 15 mg orally, dependent on the patient's weight. A second dose, when required, may be administered at least 4 hours after the first dose. More than 2 doses of Libervant should not be used to treat a single episode. More than one episode should not be treated with Libervant every five days or more than five episodes per month.
- **Nayzilam® (midazolam) 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:** The recommended dose of Valtoco nasal spray is 0.2 mg/kg to 0.5 mg/kg, depending on the patient's age and weight. 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 Libervant™, Nayzilam® and Valtoco®:** 10 spray units/films per 30 days

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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.

- ❑ Member must meet **ONE** of the following age requirements:
  - ❑ If requesting **Libervant™**, member must be between 2 to 5 years of age
  - ❑ If requesting **Nayzilam®**, member must be 12 years of age or older
  - ❑ If requesting **Valtoco®**, member must be 2 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 requested medication 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 **(verified by chart notes and/or pharmacy paid claims)**

AND

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

AND

- ❑ Requested dose does **NOT** exceed the FDA-approved maximum dose

AND

- ❑ Libervant™, Nayzilam® and Valtoco® will **NOT** be used concomitantly

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

*****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.****