



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Diacomit

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax, Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, City, State ZIP, Primary Phone, Specialty/facility name (if applicable)

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: Drug Name, Strength, Directions / SIG

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have a documented diagnosis of Dravet syndrome (DS)?

Yes checkbox

No checkbox

Q2. Is Diacomit being prescribed by or in consultation with a neurologist or epileptologist?

Yes checkbox

No checkbox

Q3. Is there documentation of an inadequate response or intolerance to at least two agents to treat Dravet syndrome: such as clobazam, valproic acid derivatives, topiramate, levetiracetam, cannabidiol (pharmaceutical)?

Yes checkbox

No checkbox

Q4. Additional Information:

Prescriber Signature

Date



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Patient Name:	Prescriber Name:
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