



Fax completed form to Navitus at: 855-668-8553  
For questions, please call: 877-908-6023

## TEXAS MEDICAID

### Drug Prior Authorization ganaxolone (ZTALMY)

#### Request Information (required)

This request is:

- Expedited\* (Urgent)**  
 **Standard (Non-Urgent)**

\*Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

#### Member Information (required)

#### Prescriber Information (required)

Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):  
(Go to #2)

2. Quantity Requested:  
(Go to #3)

3. Dose Requested (Strength):  
(Go to #4)

4. Dosing Instructions:  
(Go to #5)

**Required Criteria**

5. Provide primary diagnosis including ICD-10 code(s):  
(Go to #6)

Clinical Criteria (required)

6. Is the request for initial therapy or continuation of therapy?

Initial Request

(Go to #7)

Continuation Request

(Go to #10)

Clinical Criteria -Initial Request

7. Is the member greater than or equal to ( $\geq$ ) two (2) years of age?

Yes

(Go to #8)

No (Deny)

(Go to #8)

8. Does the member have a diagnosis of seizures associated with cyclin-dependent kinase-like 5 deficiency disorder (CDD) in the last 730 days?

Yes

(Go to #9)

No (Deny)

(Go to #9)

9. Is the requested dose less than or equal to ( $\leq$ ) 1800 mg/day?

Yes (Approve - 365 days)

(Go to #11)

No (Deny)

(Go to #11)

Clinical Criteria -Continuation Request

10. Has the member had therapy with Ztalmy for at least 90 days in the last 120 days?

Yes (Approve - 365 days)  
(Go to #11)

No (Deny)  
(Go to #11)

Additional Information

11. Please provide any additional information we should consider (or attach any supporting documents):  
(END)

**Submission Information (required)**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\* PLEASE FAX COMPLETED FORM TO: 855-668-8553 \*\***

If criteria not met, submit chart documentation with form citing complex medical circumstances.  
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