TEXAS MEDICAID
Clinical Edit Prior Authorization
stiripentol (DIACOMIT)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: COMPLETE REQUIRED CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client greater than or equal to (≥) 2 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a current claim for clobazam?

   Clobazam is also available as ONFI and SYMPAZAN.

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of Dravet Syndrome in the last 730 days?

   ☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.