



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

TEXAS MEDICAID

Drug Prior Authorization

Antiseizure Agents: stiripentol (DIACOMIT)

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 member greater than or equal to (\geq) six (6) months of age?

Yes
(Go to #7)

No (Deny)
(Go to #7)

7. Does the member weigh at least seven (7) kilograms? [Manual]

Yes

(Go to #8)

No (Deny)

(Go to #8)

8. Does the member have a current claim for clobazam (ONFI, SYMPAZAN)?

Yes

(Go to #9)

No (Deny)

(Go to #9)

9. Does the member have a diagnosis of Dravet Syndrome in the last 730 days?

Yes

(Go to #10)

No (Deny)

(Go to #10)

10. Is the requested dose less than or equal to (\leq) 3,000 mg/day?

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)

Drug Prior Authorization

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Submission Information (required)

Prescriber Signature: _____ **Date:** _____

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

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