REALRx

PRIOR AUTHORIZATION REQUEST FORM
NAYZILAM® AND VALTOCO® NASAL SPRAY

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Nayzilam® (midazolam) Nasal Spray, ☐ Valtoco® (diazepam) Nasal Spray

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is this request for an expedited review? By checking the "Yes" box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Does the member have a documented diagnosis of epilepsy?	☐	☐	**Please provide documentation**
3. Does the member have a current prescription of an antiepileptic for daily seizure maintenance therapy?	☐	☐	**Please provide documentation**
4. Is member compliant with daily antiepileptic medication therapy?	☐	☐	**Please provide documentation**
5. Does the member have intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern in patients with epilepsy?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**
3. Do updated chart notes show a plan of care?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

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Policy: PHARM-102
Origination Date: 04/19/2020
Reviewed/Revised Date: 05/17/2023
Next Review Date: 05/17/2024
Current Effective Date: 06/01/2023