Iowa Medicaid
IOWA HHS

Request for Prior Authorization
Select Anticonvulsants

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for select anticonvulsants. Payment will be considered under the following conditions:

1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2) Patient has an FDA approved or compendia indicated diagnosis, for requested drug, of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, tuberous sclerosis complex, or cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder with documentation of an adequate trial and inadequate response with at least two preferred concomitant antiepileptic drugs (AEDs), if available; and
3) Is prescribed by or in consultation with a neurologist; and
4) Patient's current weight is provided; and
5) The total daily dose does not exceed the following:
   a. Cannabidiol
      i. Lennox-Gastaut syndrome or Dravet syndrome: 20 mg/kg/day; or
      ii. Tuberous sclerosis complex: 25 mg/kg/day; or
   b. Fenfluramine
      i. With concomitant stiripentol (plus clobazam): 0.4 mg/kg/day with a maximum of 17 mg per day: or
      ii. Without concomitant stiripentol: 0.7 mg/kg/day with a maximum of 26 mg per day; or
   c. Stiripentol
      i. Prescribed concomitantly with clobazam: and
      ii. 50 mg/kg/day with a maximum of 3,000 mg per day; or
   d. Ganaxolone
      i. Weight ≤ 28 kg: 63 mg/kg/day; or
      ii. Weight > 28 kg: 1800 mg/day.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Diacomit ☐ Epidiolex ☐ Fintepla ☐ Ztalmy

Strength	Dosage Instructions	Quantity	Days Supply

Request for Prior Authorization
Select Anticonvulsants *(Continued)*

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis: _____

Patient weight (kg): _____ **Date obtained:** _____

Is prescriber a neurologist?

☐ Yes ☐ No If no, note consultation with neurologist:

Consultation date: _____ Physician name & phone: _____

_____

Document an adequate trial and inadequate response with at least two concomitant AEDs:

Trial #1 drug name and dose: _____

Trial dates: _____ Failure reason: _____

_____

Trial #2 drug name and dose: _____

Trial dates: _____ Failure reason: _____

_____

Medical or contraindication reason to override trial requirements: _____

_____

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*