



Updated: 10/2018  
PARP Approved: 10/2018

Gateway Health  
Prior Authorization Criteria  
**Diacomit (stiripentol)**

All requests for Diacomit (stiripentol) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Diacomit (stiripentol) Prior Authorization Criteria:

For all requests for Diacomit (stiripentol) all of the following criteria must be met:

- Members stabilized on the medication will not be required to try and fail formulary alternatives.
- Member must be 2 years of age or older
- Treatment is prescribed by, or in consultation with, a neurologist
- Medication must be used as adjunctive therapy with valproic acid and clobazam (prior authorization required)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of Dravet syndrome and the following criteria is met:

- Documentation that the member's seizures are uncontrolled while on stable antiepileptic drug therapy
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to the following:
  - Topiramate
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
  - Must provide documentation showing treatment with Diacomit has provided improvement in the member's condition.
- **Reauthorization duration of approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.



**DIACOMIT (STIRIPENTOL)  
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health<sup>SM</sup> Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative.

**PHONE:** (800) 392-1147 Monday through Friday 8:30am to 5:00pm

**PROVIDER INFORMATION**

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

**MEMBER INFORMATION**

Member Name:	DOB:
Gateway ID:	Member weight: _____ pounds or _____ kg

**REQUESTED DRUG INFORMATION**

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Medication Initiated:	

**Billing Information**

This medication will be billed:  at a pharmacy **OR**  
 medically (if medically please provide a JCODE: \_\_\_\_\_)

Place of Service:  Hospital  Provider's office  Member's home  Other

**Place of Service Information**

Name:	NPI:
Address:	Phone:

**MEDICAL HISTORY (Complete for ALL requests)**

Diagnosis:

Is the member's seizures currently uncontrolled on current therapy?  Yes  No

**CURRENT or PREVIOUS THERAPY**

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

**REAUTHORIZATION**

Has the member experienced a significant improvement with treatment?  Yes  No

Please describe: \_\_\_\_\_

**SUPPORTING INFORMATION or CLINICAL RATIONALE**

**Prescribing Provider Signature**

**Date**

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