Gateway Health It's Wholecare.

Updated: 09/2020
PARP Approved: 09/2020

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.

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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℠ 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:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ 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