Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Anticonvulsant Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1-year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Anticonvulsant (Onfi and clobazam tablet).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:

☐ Initial Request ☐ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Name/Strength/Formulation: _____

Sig: _____

5 – Diagnosis

Diagnosis: _____

6 – Clinical Criteria

1. Is the patient at least two years of age or older? **AND**

   ☐ Yes ☐ No

2. Does the patient have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)? **AND**

   ☐ Yes ☐ No

3. Using as adjunctive therapy with other anticonvulsants? **AND**

   ☐ Yes ☐ No

4. Please provide documentation of an insufficient response to another medication used for LGS: _____

   _____
   _____
   _____
   _____

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**