



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Clobazam - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Member Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.  
Please answer the following questions and sign.**

Q1. Does the patient have a documented diagnosis of seizures associated with Lennox-Gastaut syndrome?

Yes

No

Q2. Does the patient have a documented diagnosis of refractory seizures/epilepsy?

Yes

No

Q3. Does the patient have a diagnosis of seizures associated with Dravet syndrome?

Yes

No

Q4. Is there documentation of inadequate response, intolerance, contraindication, or is concomitantly receiving one of the following: valproate, lamotrigine, rufinamide, cannabidiol (Epidiolex), felbamate?

Yes

No

Q5. Is there documentation of inadequate response, intolerance, contraindication, or is concomitantly receiving two antiepileptics such as: felbamate, lamotrigine, levetiracetam, topiramate, valproate, zonisamide?



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<b>Member Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is clobazam being prescribed by or in consultation with a neurologist	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Requested Duration:	
<input type="checkbox"/> 12 Months	<input type="checkbox"/> Other
Q8. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2025