Prescriber Criteria Form
Clobazam 2025 PA Fax 1443-A v1 010125.docx
Anticonvulsants
Onfi, Sympazan (clobazam)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of clobazam.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Is the patient 2 years of age or older? [No further questions.]	Yes ◯	No ◯
3	Is the requested drug being prescribed for treatment of seizures associated with Dravet syndrome?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____