Prescriber Criteria Form

Diacomit 2025 PA Fax 2779-A v1 010125.docx
Diacomit (stiripentol)
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 Diacomit (stiripentol).

Drug Name:
Diacomit (stiripentol)

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 treatment of seizures associated with Dravet syndrome? [If no, then no further questions.]	Yes ◯	No ◯
2	Will the patient be taking the requested drug concurrently with clobazam? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the patient 6 months of age or older? [If no, no further questions.]	Yes ◯	No ◯
4	Does the patient weigh 7 kilograms or more?	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:**_____