Prescriber Criteria Form

Valium 2025 PA Fax 5774-B v2 010125.docx
Valium (diazepam tablet), Diazepam Oral Solution, Diazepam Oral Solution Concentrate
Prior Authorization applies only to patients 65 years of age or older.
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 Diazepam.

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	Does the benefit of therapy with this prescribed medication outweigh the potential risks for the patient? [Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.] [If no, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for one of the following: A) symptomatic relief in acute alcohol withdrawal, B) use as an adjunct for the relief of spasticity caused by upper motor neuron disorders (e.g., cerebral palsy and paraplegia), athetosis, or stiff-man syndrome, C) adjunctive therapy in the treatment of convulsive disorders? [If yes, then no further questions.]	Yes ◯	No ◯
3	Is the requested drug being prescribed for use as an adjunct for the relief of skeletal muscle spasms due to reflex spasm to local pathology (e.g., inflammation of the muscles or joints, or secondary to trauma)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Is the requested drug being prescribed for the short-term relief of the symptoms of anxiety? [If yes, then no further questions.]	Yes ◯	No ◯

5	Is the requested drug being prescribed for management of an anxiety disorder? [If no, then no further questions.]	Yes ◯	No ◯
6	Is the requested drug being used concurrently with a selective serotonin reuptake inhibitor (SSRI) OR a serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety? [If yes, then no further questions.]	Yes ◯	No ◯
7	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to AT LEAST TWO agents from the following classes: A) selective serotonin reuptake inhibitors (SSRIs), B) serotonin-norepinephrine reuptake inhibitors (SNRIs)?	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:**_____