Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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Montana Healthcare Programs Prior Authorization Request Form for Use of Ztalmy® (ganaxolone)

Member name:	DOB:	Date:
Member ID:	Prescriber phone:	
Prescriber name and specialty if applicable:	Prescriber fax:	
Dosage requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ **INITIATION OF THERAPY**

Member must meet all the following:

1. Member is 2 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of a pathogenic or likely pathogenic mutation in the CDKL5 gene: ☐ Yes ☐ No
3. Medication is prescribed by or in consultation with a neurologist: ☐ Yes ☐ No

   Action Required: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult).

   Name of specialist: _____ **Contact date**: _____
4. Seizures are inadequately controlled by at least two other conventional antiepileptic therapies: ☐ Yes ☐ No

   Drug name: _____ **Dates of use**: _____

   Drug name: _____ **Dates of use**: _____

   LIMITATIONS:

   Maximum daily dose is weight based:

   - ≤ 28 kg = 63 mg/kg per day
   - > 28 kg = 1800 mg per day

Initial authorization will be issued for 16 weeks.

☐ **CONTINUATION OF THERAPY**

- Member has documentation of positive clinical response to Ztalmy®**,** showing a decreased number of seizures compared to baseline: ☐ Yes ☐ No
- Annual specialist consult is attached if prescriber is not a specialist: ☐Yes ☐ No ☐ N/A prescriber is a specialist

Reauthorization will be issued for 1 year.

Please complete form, including required attachments and fax to
Drug Prior Authorization Unit at 1-800-294-1350