Mountain Pacific
INNOVATING BETTER HEALTH
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# Montana Healthcare Programs Prior Authorization Request Form for Use of Diacomit® (stiriptentol)

| | | |
|---|---|---|
| Member Name: | DOB: | Date: |
| Member ID: | Prescriber Phone: | |
| Prescriber Name/Specialty (*if applicable*): | Prescriber Fax: | |
| Requested Drug/Dose/Directions: | | |

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

☐ **INITIATION OF THERAPY**

1. Member is 6 months of age or older AND weighs at least 7kg: ☐ Yes ☐ No
   Current weight: _____
2. Member has a diagnosis of Dravet syndrome: ☐ 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. Member is concurrently taking clobazam: ☐ Yes ☐ No
5. Seizures have been inadequately controlled by two (2) oral anti-epileptic therapies indicated for Dravet syndrome:
   Drug name: _____ Dates of use: _____
   Drug name: _____ Dates of use: _____
6. Provider attests to the following:
   - ☐ Baseline neutrophil and platelet count have been preferred and drug interactions have been reviewed.
   - ☐ Baseline seizure activity has been documented.

**LIMITATIONS:**
Maximum daily dose:

- 3000mg daily in children 1 year old or older AND weighing ≥10kg
- 50mg/kg/day in children at least 6 months old AND weighing 7 to <10kg

**Initial authorization will be granted for 1 year.**

☐ **CONTINUATION OF THERAPY**

- Member has documentation of positive clinical response to therapy (i.e., reduction in the frequency of seizures from baseline): ☐ Yes ☐ No
- Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – prescriber is specialist.

**LIMITATIONS:**

Maximum daily dose:

- 3000mg daily in children 1 year old or older AND weighing ≥10kg
- 50mg/kg/day in children at least 6 months old AND weighing 7 to <10kg

**Reauthorization will be issued for 1 year.**

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

09/2023