**CAREFIRST**
**Valtoco**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Valtoco.

## Patient Information

**Patient Name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**Patient Phone:** ☐☐☐-☐☐☐-☐☐☐☐

**Patient ID:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**Patient Group:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**Patient DOB:** ☐☐/☐☐/☐☐☐☐

## Physician Information

**Physician Name** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**Physician Phone:** ☐☐☐-☐☐☐-☐☐☐☐

**Physician Fax:** ☐☐☐-☐☐☐-☐☐☐☐

**Physician Addr.:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

**City, St, Zip:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

## Drug Name (select from list of drugs shown)

Valtoco 5mg (diazepam nasal spray) Valtoco 20mg (diazepam nasal spray) Valtoco 15mg (diazepam nasal spray)
Valtoco 10mg (diazepam nasal spray)

**Quantity:** _____ **Frequency:** _____ **Strength:** _____

**Route of Administration:** _____ **Expected Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____

_____

## Please check the appropriate answer for each applicable question.

| | | | |
|---|---|---|---|
| 1. | Is the requested drug being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from the patient's usual seizure pattern in a patient with epilepsy? | **Y** ☐ | **N** ☐ |
| 2. | Is the patient 6 years of age or older? | **Y** ☐ | **N** ☐ |
| 3. | Does the patient require more than the plan allowance per month of 10 blister packs (5 cartons) of the requested drug? | **Y** ☐ | **N** ☐ |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

**Prescriber (Or Authorized) Signature and Date**

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