Prescriber Criteria Form

Diazepam PA Plus 2024 PA Fax 1473-B v1 010124.docx
Diazepam oral solution, Diazepam Oral Solution Concentrate, Valium (diazepam tablet)
Prior Authorization applies only to patients 65 years of age or older
Prior Authorization applies to greater than cumulative 5 days of therapy per year
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 American Geriatrics Society identifies the use of this medication as 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: ____________________