



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Anticonvulsants

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. For a non-preferred Anticonvulsant, has a current history (within the past 90 days) of being prescribed the same non-preferred Anticonvulsant (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred).

Yes

No

Q2. For a diagnosis of a seizure disorder, has a history of therapeutic failure of or a contraindication or an intolerance to two preferred Anticonvulsants approved or medically accepted for the beneficiary's diagnosis (therapeutic failure of preferred Anticonvulsants must include the generic equivalent when the generic equivalent is designated as preferred).

Yes

No

NA

Q3. For all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Anticonvulsants approved or medically accepted for the beneficiary's diagnosis (therapeutic failure of preferred Anticonvulsants must include the generic equivalent when the generic equivalent is designated as preferred).

Yes

No

Q4. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication.

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Yes

No

Q5. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Yes

No

Q6. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Yes

No

Q7. For Epidiolex (cannabidiol), select all that apply:

Has a history of therapeutic failure of or a contraindication or an intolerance to two preferred Anticonvulsants approved or medically accepted for the beneficiary's diagnosis.

Has a history of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex.

Not applicable

Q8. For clonazepam, beneficiary is under 21 years of age, select all that apply:

Has a diagnosis of one of the following: 1) Seizure disorder, 2) Chemotherapy induced nausea and vomiting, 3) Cerebral palsy, 4) Spastic disorder, 5) Dystonia, 6) Catatonia.

Is receiving palliative care.

Not applicable

Q9. For therapeutic duplication of clonazepam with another benzodiazepine, select all that apply:

Is being titrated to or tapered from another benzodiazepine.

Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines.

Not applicable

Q10. When there is a record of two or more paid claims for any benzodiazepine, select all that apply:



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The multiple prescriptions are consistent with medically accepted prescribing practices and standards of care, including support from peer-reviewed medical literature or national treatment guidelines.

The multiple prescriptions are written by the same prescriber or, if written by different prescribers, all prescribers are aware of the other prescription(s).

Not applicable

Q11. For a beneficiary with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder, select all that apply:

Is prescribed the buprenorphine agent and clonazepam by the same prescriber or, if prescribed by different prescribers, all prescribers are aware of the other prescription(s).

Has an acute need for therapy with clonazepam.

Not applicable

Q12. Additional Information:

Prescriber Signature

Date

v2026-06