OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Onfi® (clobazam) & Sympazan™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Continuation of therapy:

Is the patient established on the requested medication? ❑ **Yes** ❑ **No**

Is this for a continuation of prior therapy? ❑ **Yes** ❑ **No**

If yes, is it for a seizure disorder? ❑ **Yes** ❑ **No**

Select the diagnosis below:

❑ Seizures associated with Lennox-Gastaut syndrome (LGS)

❑ Refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs) **[Onfi (clobazam)** only**]**

❑ Other diagnosis: ____________________________ ICD-10 Code(s): ____________________________

Clinical information:

Is the requested medication being prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Is the requested medication being used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)? ❑ **Yes** ❑ **No**

Is the requested medication being used as primary treatment? ❑ **Yes** ❑ **No**

For Sympazan requests, also answer the following:

Does the patient have a trial and failure or intolerance to generic clobazam tablets or oral suspension? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to the requested medication? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Onfi-Sympazan_Comm_2019Feb-W