TRICARE Prior Authorization Request Form for
ganaxolone oral suspension (Ztalmy)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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**FAX Completed Form and Applicable Progress Notes to: (410) 424-4037**

# USFHP Pharmacy Prior Authorization Form

| To be completed by Requesting provider | |
|---|---|
| Drug Name: | Strength: |
| Dosage/Frequency (SIG): | Duration of Therapy: |

***Questions?*** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**Step 1** **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

**Step 2** **Please complete the clinical assessment:**

| | | |
|---|---|---|
| **1. Is the requested medication prescribed by or in consultation with a pediatric neurologist?** | ☐ Yes<br>Proceed to question 2 | ☐ No<br>**STOP**<br>Coverage not approved |
| **2. Does the patient have a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder confirmed with a genetic test?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>Coverage not approved |

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[9 November 2022]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |