Prescriber Criteria Form Zonisade 2024 PA Fax 5624-A v1 010124.docx Zonisade (zonisamide suspension) 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 Zonisade (zonisamide suspension).

Drug Name: Zonisade (zonisamide suspension)

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	Is the requested drug being prescribed as adjunctive therapy for the treatment of partial-onset seizures (i.e., focal-onset seizures)? [If no, then no further questions.]	Yes	No
2	Does the patient have difficulty swallowing solid oral dosage forms (e.g., tablets, capsules)? [If yes, then skip to question 5.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to a generic anticonvulsant? [If no, then no further questions.]	Yes	No
4	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to any of the following: A) Aptiom, B) Xcopri, C) Spritam? [If no, then no further questions.]	Yes	No
5	Is the patient 16 years of age or older?	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: _____