Prescriber Criteria Form

Tranxene T 2026 PA Fax 1466-B v1 010126.docx
Tranxene T-Tab (clorazepate dipotassium)
Prior Authorization applies only to patients 65 years of age or older.
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 Tranxene T-Tab (clorazepate dipotassium).

Drug Name:
Tranxene T-Tab (clorazepate dipotassium)

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 use of this medication is 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 patient using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug? [If no, then skip to question 4.]	Yes	No
3	Has the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient? [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.] [If no, then no further questions.]	Yes	No
4	Is the requested drug being prescribed for either of the following: A) adjunctive therapy in the management of partial seizures, B) symptomatic relief of acute alcohol withdrawal? [If yes, then no further questions.]	Yes	No

5	Is the requested drug being prescribed for the short-term relief of the symptoms of anxiety? [If yes, then no further questions.]	Yes	No
6	Is the requested drug being prescribed for the management of an anxiety disorder? [If no, then no further questions.]	Yes	No
7	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
8	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:**_____