Sedative/Hypnotics — Nonbenzodiazepine Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: ____________________	Prescribing physician: ____________________
Patient ID #: ____________________	Physician address: ____________________
Patient DOB: ____________________	Physician phone #: ____________________
Date of Rx: ____________________	Physician fax #: ____________________
Patient phone #: ____________________	Physician specialty: ____________________
Patient email address: ____________________	Physician DEA: ____________________
	Physician NPI #: ____________________
	Physician email address: ____________________

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
____________	____________	____________	Specify: ____________

7. Diagnosis: ____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. Requests for doses above the manufacturer recommended dose will not be considered.

PA is required for all nonpreferred nonbenzodiazepine sedative/hypnotics. Payment for nonpreferred nonbenzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of a previous trial and therapy failure with, at a minimum, 3 preferred agents. Payment for nonpreferred nonbenzodiazepine sedative/hypnotics will be considered when the following criteria are met:

1. A diagnosis of insomnia
2. Medications with a side effect of insomnia (for example, stimulants) are decreased in dose, changed to a short acting product and/or discontinued
3. Enforcement of good sleep hygiene is documented
4. All medical, neurological and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses
5. In addition to the above criteria, requests for suvorexant (Belsomra) will require documentation of a trial and therapy failure with at least 1 nonpreferred agent, other than suvorexant, prior to consideration of coverage

6. Nonpreferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system (if available)

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred	**Nonpreferred**			
☐ Eszopiclone	☐ Ambien	☐ Edluar	☐ Rozerem	☐ Zolpimist
☐ Zeleplon	☐ Ambien CR	☐ Intermezzo	☐ Sonata	
☐ Zolpidem	☐ Belsomra	☐ Lunesta	☐ Zolpidem ER	
	☐ Dayvigo	☐ Ramelteon	☐ Zolpidem SL tab	

Diagnosis: ____ Date of diagnosis: ____________________________________
Comorbid conditions contributing to insomnia: ____
____

Nonpharmacological treatments tried: ____

Requests for nonpreferred drugs
Eszopiclone trial
Dose: _________________________Trial start date: ____________________Trial end date: _________________________
Reason for failure: ____

Zaleplon trial
Dose: _________________________Trial start date: ____________________Trial end date: _________________________
Reason for failure: ____

Zolpidem trial:
Dose: _________________________Trial start date: ____________________Trial end date: _________________________
Reason for failure: ____

Requests for belsomra (in addition to 3 trials above):
Trial of nonpreferred agent
Dose: _________________________Trial start date: ____________________Trial end date: _________________________
Reason for failure: ____

Medical necessity for alternative delivery system: ____
Reason for use of nonpreferred drug requiring prior approval: ____

Attach lab results and other documentation as necessary.

9. Physician signature

Prescriber or authorized signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.