



Please complete ALL information below and fax your request to 1-888-671-5285

Benzodiazepines Coverage Determination Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		Office Contact:
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)			Strength:		Dosage Form:
<input type="checkbox"/> Check if request is for continuation of therapy			Directions for Use:		
Clinical Information <small>(required)</small>					
Select the Type(s) of Coverage Determination Requested:					
<input type="checkbox"/> Non-Formulary - Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.					
<input type="checkbox"/> Step Therapy - Request is for an exception to try another drug before the requested drug being prescribed.					
<input type="checkbox"/> Quantity Limit - Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____					
Select the diagnosis below:					
<input type="checkbox"/> Acute alcohol withdrawal					
<input type="checkbox"/> Adjunctive therapy of skeletal muscle spasm					
<input type="checkbox"/> Anxiety disorder					
<input type="checkbox"/> Panic disorder					
<input type="checkbox"/> Seizure disorders					
<input type="checkbox"/> Adjunctive therapy of partial seizure					
<input type="checkbox"/> Short-term insomnia					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Select the medication(s) the patient has a history of trial and failure, or intolerance to:					
<input type="checkbox"/> Alprazolam		<input type="checkbox"/> Clorazepate		<input type="checkbox"/> Lorazepam	
<input type="checkbox"/> Alprazolam Intensol		<input type="checkbox"/> Diazepam		<input type="checkbox"/> Oxazepam	
<input type="checkbox"/> Clonazepam		<input type="checkbox"/> Diazepam Intensol		<input type="checkbox"/> Temazepam	
<input type="checkbox"/> Clonazepam orally disintegrating tablet (ODT)		<input type="checkbox"/> Estazolam			
<input type="checkbox"/> Other drugs in the same class. Please specify: _____					
<input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____					
Quantity limit requests:					
Is there a high risk of significant adverse clinical outcome with medication change or dosage change? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please specify: _____					

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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.