FUTURE SCRIPTS

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

Sleep Agents Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Insomnia

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has had an inadequate response to or an inability to tolerate:

❑ Eszopiclone

❑ Zaleplon

❑ Zolpidem

❑ Zolpidem extended-release (ER)

❑ Zolpidem sublingual (SL)

❑ Other (Please specify all agents): _____

For Edluar 5mg, Intermezzo 1.75mg, Zolpimist requests, also answer the following:

Does the patient have an inability to swallow capsules/tablets (e.g., dysphagia, gastrointestinal [GI] tubes)? ❑ **Yes** ❑ **No**

For Ambien (zolpidem) 10mg, Ambien CR (zolpidem ER) 12.5mg, Edluar 10mg, Intermezzo (zolpidem SL) 3.5mg, and Lunesta (eszopiclone) 3mg, also answer the following:

Has the patient been counseled on practices associated with good sleep hygiene (e.g. avoiding stimulants such as caffeine, nicotine, alcohol close to bed time, etc.)? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to a two week trial of the lower dose? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

Is there documentation of the inability to reach the requested dose with higher strengths of commercially available dosage forms due to patient specific characteristics (i.e. inability to swallow larger pills, malabsorption, presence of a feeding tube, etc)? ❑ **Yes** ❑ **No**

Is the requested dose commercially available? ❑ **Yes** ❑ **No**

Is there documentation the dose requested is medically necessary? ❑ **Yes** ❑ **No**

If YES, please specify: _____

_____

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.