



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)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)
Select the diagnosis below: <input type="checkbox"/> Insomnia <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Select the medications the patient has had an inadequate response to or an inability to tolerate: <input type="checkbox"/> Eszopiclone <input type="checkbox"/> Zolpidem extended-release (ER) <input type="checkbox"/> Zaleplon <input type="checkbox"/> Zolpidem sublingual (SL) <input type="checkbox"/> Zolpidem <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had an inadequate response to a two week trial of the lower dose? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested dose commercially available? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there documentation the dose requested is medically necessary? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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