



Request for Prior Authorization

FAX Completed Form To
(800) 574-2515

SEDATIVE/HYPNOTICS-NON-
BENZODIAZEPINE

Provider Help Desk
(877) 776-1567

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits.

PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with, at a minimum, three (3) preferred agents.

Preferred

Non-Preferred

- Checkboxes for Eszopiclone, Zaleplon, Zolpidem, Ambien, Ambien CR, Belsomra, Dayvigo, Edluar, Lunesta, Quviviq, Ramelteon, Rozerem, Zolpimist, Zolpidem ER, Zolpidem SL Tab.

Strength Dosage Instructions Quantity Days Supply

Diagnosis Date of Diagnosis:

Co-Morbid Conditions Contributing to Insomnia:

Non-Pharmacological Treatments Tried:

Requests for Non-Preferred 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:

**Request for Prior Authorization**

**SEDATIVE/HYPNOTICS-NON-BENZODIAZEPINE**

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**Will requested agent be used concurrently with a benzodiazepine sedative/hypnotic?**

Yes Drug Name: \_\_\_\_\_  No

**Requests for Orexin Receptor Antagonist (in addition to three (3) trials above):**

**Trial of Non-Preferred Agent:** Drug Name & Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

Medical Necessity for alternative delivery system: \_\_\_\_\_

Reason for use of Non-Preferred drug requiring prior approval: \_\_\_\_\_

**Attach lab results and other documentation as necessary (Required).**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.