

US Family Health Plan Pharmacy Program

Newer Sedative Hypnotics Prior Authorization Request Form

This form applies to the US Family Health Plan Mail Order Pharmacy and the US Family Health Plan Retail Pharmacy programs. This form must be completed and signed by the prescriber.

PLEASE NOTE:

- **NO prior authorization is required for zolpidem immediate-release tablet (Ambien).**
- Prior authorization for the non-preferred agents zolpidem ER (Ambien CR), Edluar, Lunesta, Rozerem, Silenor, Sonata, or Zolpimist is NOT required for patients who are currently receiving these medications based on prescriptions filled during the last 6 months, or if there has been a trial of the preferred agent zolpidem immediate-release tablet based on prescriptions filled during the last 6 months.

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here
	<ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 <li style="text-align: center; padding: 5px 0;">OR The completed form may be faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at: http://www.usfamilyhealth.org/fdownloadable_forms.html

- Drug for which Prior Authorization is requested:**
- | | |
|--|--|
| <input type="checkbox"/> Ambien CR (zolpidem ER tablet) | <input type="checkbox"/> Rozerem (ramelteon) |
| <input type="checkbox"/> Edluar (zolpidem sublingual tablet) | <input type="checkbox"/> Silenor (doxepin) |
| <input type="checkbox"/> Lunesta (eszopiclone) | <input type="checkbox"/> Sonata (zaleplon) |
| | <input type="checkbox"/> Zolpimist (zolpidem oral spray) |

Step 1 Please complete patient and physician information (Please Print)

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID: _____	Phone #: _____
	Date of Birth: _____	Secure Fax: _____

Step 2 Please complete the clinical assessment:

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1. Has the patient received a trial of zolpidem immediate-Release tablet (Ambien) and had an inadequate response?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 2
2. Has the patient received a trial of zolpidem immediate-Release tablet (Ambien), but was unable to tolerate it due to adverse effects?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 3
3. Is treatment with zolpidem immediate-release tablet (Ambien) contraindicated for this patient (e.g., due to hypersensitivity)?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 4
4. Is the medication being prescribed Rozerem or Silenor?	<input type="checkbox"/> Yes Proceed to Question 5	<input type="checkbox"/> No Proceed to Question 6
5. Is Rozerem or Silenor considered to be the most clinically suitable choice for this patient due to its apparent lack of abuse potential?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Coverage not approved
6. Is the requested medication Edluar or Zolpimist AND the patient has swallowing difficulties?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Coverage not approved

Step 3 I certify the above is correct and accurate to the best of my knowledge. Please sign and date

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Prescriber Signature

Date