



**PRIOR AUTHORIZATION FORM  
Select Hypnotics**

DATE OF REQUEST: \_\_\_\_\_

MEMBER INFORMATION

NAME \_\_\_\_\_

ID # \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

**PLEASE NOTE:** By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME \_\_\_\_\_

NPI # \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_

CONTACT NAME \_\_\_\_\_

PROVIDER SIGNATURE \_\_\_\_\_

All products **identified in this policy** and their corresponding generics are limited to **15 dosage units every 30 days**. Prior authorization is required for quantities exceeding this limit. *Note: Quantity limits for Medicare Part D may differ.*

**Requested Medication (check only ONE and specify dosage):**

**Non-benzodiazepines:**

\*All brand name products in this category will automatically pay ONLY if the member has at least 1 paid claim for zolpidem or zaleplon in the previous 365 days.

Ambien  Ambien CR  zolpidem/CR

Lunesta  Rozerem  Edluar

Sonata  zaleplon

Dosage: \_\_\_\_\_

**Benzodiazepines:**

Dalmane (flurazepam)  Doral (quazepam)

Prosom (estazolam)  Halcion (triazolam)

Restoril (temazepam)

Dosage: \_\_\_\_\_

Diagnosis \_\_\_\_\_

Please check one  Initial Request

ICD-9 code \_\_\_\_\_

Extension Request

**Previous Medication History**

**Rationale for Discontinuation**


Additional Information \_\_\_\_\_

**Rationale for Request** (co-morbidities, allergies, etc) \_\_\_\_\_

**Submit chart notes to identify all of the following:**

- All other treatments have been tried
- Expected duration of requested treatment
- Outcome for each previous drug trial
- All other pertinent information

**PLEASE NOTE:** ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

*Refer to the MVP Formulary at [www.mvphealthcare.com](http://www.mvphealthcare.com) for those drugs that require prior authorization or are subject to quantity limits or step therapy.*

**FAX THIS REQUEST TO:**

Commercial **1-800-376-6373**  
(HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**  
(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)