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.

PRESCRIBING PHYSICIAN INFORMATION

NAME _____

NPI # _____

ADDRESS _____

_____

PHONE # _____FAX #_____

CONTACT NAME _____

PROVIDER SIGNATURE _____

All products **identified in this policy** and their corresponding generics are limited to **30 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 ☐ Intermezzo

☐ Lunesta ☐ Rozerem ☐ Edluar ☐ Belsomra

☐ Sonata ☐ zaleplon ☐ Zolpimist ☐ zolpidem ER

Dosage: _____

Benzodiazepines:

☐ Dalmane (flurazepam) ☐ Doral (quazepam)

☐ Prosom (estazolam) ☐ Halcion (triazolam)

☐ Restoril (temazepam)

Dosage: _____

Diagnosis_____ **ICD-10 code** _____

Please check one □ **Initial Request** □ **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** 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, Exchange, Medicaid, Child Health Plus, ASO)

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