

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

 This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Hypnotics (Ambien CR, Lunesta, Sonata) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- | | | | |
|------------|--|--|---------------------------------------|
| Ambien CR: | <input type="checkbox"/> 6.25 mg tablets | <input type="checkbox"/> 12.5 mg tablets | |
| Lunesta: | <input type="checkbox"/> 1 mg tablets | <input type="checkbox"/> 2 mg tablets | <input type="checkbox"/> 3 mg tablets |
| Sonata: | <input type="checkbox"/> 5 mg capsules | <input type="checkbox"/> 10 mg capsules | |

Dose: _____ Start date: _____

Priority Health Precertification Requirements:
Authorization of hypnotics requires:

- Diagnosis of insomnia
- Age of 18 years or older
- Documented therapeutic trial of all of the following: temazepam, estazolam, triazolam, flurazepam, and zolpidem
- Authorization of hypnotics are limited to a maximum of once per day

Please Complete the Following Information:

Diagnosis:

- Insomnia
 Other: _____ Please provide rationale for use: _____

Patient's age: _____

Patient has had a therapeutic trial and clinical failure with all of the following:

- Yes
- | | | |
|-------------------------------------|----------------------|---------------|
| <input type="checkbox"/> temazepam | Date of Trial: _____ | Result: _____ |
| <input type="checkbox"/> estazolam | Date of Trial: _____ | Result: _____ |
| <input type="checkbox"/> triazolam | Date of Trial: _____ | Result: _____ |
| <input type="checkbox"/> flurazepam | Date of Trial: _____ | Result: _____ |
| <input type="checkbox"/> zolpidem | Date of Trial: _____ | Result: _____ |
- No – Rationale for use: _____

Request is for once daily dosing:

- Yes
- No – Rationale for use: _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX