PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Eszopiclone

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug information

☐ New request ☐ Continuation request

Drug product:
- ☐ Eszopiclone 1 mg tablet
- ☐ Eszopiclone 2 mg tablet
- ☐ Eszopiclone 3 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically accepted indication* not otherwise excluded from coverage under Medicare Part D
2. Additional criteria based on age and amount of eszopiclone needed per year (see table):

Age	Amount needed per 365 days	Additional criteria	Type of exception needed if criteria not met
< 65	≤ 90 tablets (short-term insomnia)	None	-
< 65	> 90 tablets (long-term insomnia)	Quantity Limit Exception criteria (see *Medicare Exception Request* section)	Quantity limit exception
≥ 65	≤ 90 tablets (short-term insomnia)	None	-
≥ 65	> 90 tablets (long-term insomnia)	Must try and fail ramelteon (Rozerem) AND temazepam	Prior authorization exception

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2020
Last reviewed 01/2020

Additional information

Note: When coverage criteria are met, coverage duration is 1 year.

The American Geriatric Society (AGS) classifies eszopiclone as a high-risk medication when used in persons age 65 and older at doses exceeding 90 days each year. AGS recommends limiting the use of this drug in the elderly to treatment of no more than 90 days a year. Priority Health offers several alternatives on our Drug List that are not considered high-risk when used for more than 90 days. These alternatives include, but are not limited to, trazodone, temazepam, and Rozerem

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- —— *or* —— supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Insomnia

☐ *Other – the patient's condition is:* _____

Rationale for Other use: _____

B. Is the patient 65 years or older AND needs more than 90 tablets per year (e.g., long-term insomnia)?

☐ No, 90 tablets or less each year is enough (no further criteria to be met)

☐ Yes

1.) If yes, has the patient tried ramelteon (Rozerem)?

☐ Yes

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

2.) If yes, has the patient tried temazepam?

☐ Yes

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

C. Is the patient less than 65 years AND needs more than 90 tablets every 365 days?

☐ No, 90 tablets or less per 365 days is enough (no further criteria to be met)

☐ Yes, a quantity limit exception is needed. **Answer the *Medicare Exception Request* questions below.**

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2020
Last reviewed 01/2020

Priority Health Medicare Exception Request

Quantity Limit Exception *(exceptions to the quantity limit of 90 tablets per 365 days)*

1. **Would the restriction of 90 tablets each year likely be ineffective to treat the patient's condition?**
   - ☐ No
   - ☐ Yes. **Please explain:** _____

2. **Would the restriction of 90 tablets each year likely cause the patient to become noncompliant?**
   - ☐ No
   - ☐ Yes. **Please explain:** _____

Prior Authorization Exception *(exceptions to the criteria for members ≥ 65 years)*

- Answer the *Precertification Documentation* questions above

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2020
Last reviewed 01/2020