pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

SEDATIVE HYPNOTICS PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines for Sedative Hypnotics, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Sedative Hypnotics** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- These agents are also subject to quantity limits – if the requested quantity exceeds the limit, please submit supporting chart documentation (list of limits accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request PA#:_____	total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Ambien tablet
☐Ambien CR tablet
☐Belsomra tablet
☐Edluar SL tablet
☐estazolam tablet
☐eszopiclone tablet
☐flurazepam capsule
☐Halcion tablet
☐Hetlioz capsule
☐Intermezzo SL tablet
☐Lunesta tablet
☐Restoril capsule
☐Rozerem tablet
☐Silenor tablet
☐Sonata capsule
☐temazapam 7.5 mg capsule
☐temazepam 22.5 mg capsule
☐triazolam tablet
☐zaleplon capsule
☐zolpidem ER tablet
☐zolpidem SL tablet
☐Zolpimist spray

Strength:	Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (required):	

Section A: Hetlioz requests	
1. Does the Recipient have a diagnosis of non-24-hour sleep-wake disorder?	☐Yes – *submit documentation of diagnosis* ☐No
2. Is the Recipient totally blind?	☐Yes – *submit medical record documentation* ☐No
3. Has the Recipient tried and failed a 6-month course of melatonin, or does the Recipient have an intolerance or contraindication to melatonin?	☐Yes – *submit all supporting documentation of drug regimen and treatment outcome* ☐No
Section B: All other non-preferred requests	
1. Has the Recipient's tried and failed any of the preferred Sedative Hypnotics? ☐temazepam 15 mg or 30 mg capsule ☐zolpidem tablet	☐Yes – *submit all supporting documentation of drug regimen and treatment outcome* ☐No
2. Does the Recipient have a contraindication or intolerance to any of the preferred agents in question (1)?	☐Yes – *submit all supporting documentation of drug regimen and treatment outcome* ☐No
3. Did the prescriber or prescriber's delegate search the PDMP to review the Recipient's controlled substance prescription history before issuing this prescription for the requested agent?	☐Yes ☐No *Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: