

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	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	Prescriber name:	
<input type="checkbox"/> Renewal request	# of pages in request: _____		
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:	<input type="checkbox"/> Ambien	<input type="checkbox"/> eszopiclone	<input type="checkbox"/> Lunesta	<input type="checkbox"/> temazepam 7.5 mg
	<input type="checkbox"/> Ambien CR	<input type="checkbox"/> flurazepam	<input type="checkbox"/> Restoril	<input type="checkbox"/> temazepam 22.5 mg
	<input type="checkbox"/> Belsomra	<input type="checkbox"/> Halcion	<input type="checkbox"/> Rozerem	<input type="checkbox"/> triazolam
	<input type="checkbox"/> Edluar	<input type="checkbox"/> Hetlioz	<input type="checkbox"/> Silenor	<input type="checkbox"/> zaleplon
	<input type="checkbox"/> estazolam	<input type="checkbox"/> Intermezzo	<input type="checkbox"/> Sonata	<input type="checkbox"/> zolpidem ER

Strength:	Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (required):	

Section A: Hetlioz requests

1. Does the Recipient have a diagnosis of non-24-hour sleep-wake disorder?	<input type="checkbox"/> Yes – <i>submit documentation of diagnosis</i> <input type="checkbox"/> No
2. Is the Recipient totally blind?	<input type="checkbox"/> Yes – <i>submit medical record documentation</i> <input type="checkbox"/> 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?	<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and treatment outcome</i> <input type="checkbox"/> No

Section B: All other non-preferred requests

1. Has the Recipient's tried and failed any of the preferred Sedative Hypnotics? <input type="checkbox"/> temazepam 15 mg or 30 mg capsule <input type="checkbox"/> zolpidem tablet	<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and treatment outcome</i> <input type="checkbox"/> No
2. Does the Recipient have a contraindication or intolerance to any of the preferred agents in question (1)?	<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and treatment outcome</i> <input type="checkbox"/> No

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

Prescriber Signature:	Date:
------------------------------	--------------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.