US Family Health Plan
Prior Authorization Request Form for
suvorexant (**Belsomra**), lemborexant (**Dayvigo**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a documented diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Have non-pharmacologic therapies been inadequate in improving functional impairment, including but not limited to, relaxation therapy, cognitive therapy, sleep hygiene?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient failed, or had clinically significant adverse effects to zolpidem extended-release AND eszopiclone?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a current or previous history of narcolepsy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **5**
5. Does the patient have a current or previous history of drug abuse?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[27 May 2020]