US Family Health Plan

Prior Authorization Request Form for Newer Sedative Hypnotics: Ambien CR, Edluar (zolpidem sublingual tablet), Intermezzo (zolpidem sublingual tablet), Lunesta, Rozerem (ramelteon), Silenor (doxepin), Zolpimist (zolpidem oral spray)

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 **617-562-5296**

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. Has the patient tried zolpidem immediate-release (IR) oral tablet, zaleplon, zolpidem ER, or eszopiclone and had an inadequate response or was unable to tolerate it due to adverse effects?	☐ Yes Sign and date below	☐ No Proceed to question 2
2. Is treatment with zolpidem immediate-release (IR) oral tablet, zaleplon, zolpidem ER, or eszopiclone contraindicated for this patient, for example, due to hypersensitivity, aberrant behaviors, or intolerable rebound insomnia?	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Which medication is requested?	☐ **Edluar, Intermezzo, Zolpimist** – Proceed to question **4**	
	☐ **Rozerem, Silenor** – Proceed to question **5**	
	☐ **All other agents** – **STOP**: **Coverage not approved**	
4. *(Edluar, Intermezzo, Zolpimist request)* **Does the patient have swallowing difficulties?**	☐ Yes Sign and date below	☐ No Coverage not approved
5. *(Rozerem, Silenor request)* **Is the requested medication the most clinically suitable choice for this patient due to its apparent lack of abuse potential?**	☐ Yes Sign and date below	☐ No Coverage not approved

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

Prescriber Signature _____ Date _____

[02 August 2017]