US Family Health Plan

TRICARE Prior Authorization Request Form for

Suvorexant (Belsomra), Lemborexant (Dayvigo), Daridorexant (Quviviq)

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**

Clinical documentation may be required for approval.

Initial and renewal prior authorization expires after 1 year. For renewal of therapy an initial prior authorization approval is required.

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. The provider acknowledges that the following agents are available without prior authorization: zolpidem IR and ER, zaleplon, eszopiclone.	☐ Acknowledged Proceed to question **2**	
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.	☐ Yes (subject to verification) Proceed to question **3**	☐ No Proceed to question **6**
3. Has the patient adequately responded to non-pharmacologic therapies?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Does the patient agree to continue with non-pharmacologic therapies including but not limited to relaxation therapy, cognitive behavioral therapy for insomnia (CBT-I), and/or sleep hygiene?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient continue to respond to the drug?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a documented diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Have non-pharmacologic therapies been inadequate in improving functional impairment, including but not limited to, relaxation therapy, cognitive behavioral therapy for insomnia (CBT-I), sleep hygiene, and will the patient continue with non-pharmacologic therapies throughout treatment?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient failed, or had clinically significant adverse effects to zolpidem extended-release OR eszopiclone?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have a current or previous history of narcolepsy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Does the patient have a current or previous history of substance and/or alcohol use disorder?	☐ 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