EXPRESS SCRIPTS®

Prior Authorization Form
Sedative Hypnotic Step Therapy

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-800-357-9577**
If this an **URGENT** request, please call 1-800-417-8164

Patient Information

Patient First Name: ______________________________

Patient Last Name: _______________________________

Patient ID#: _____________________________________

Patient DOB: ____________________________________

Patient Phone #: _________________________________

Prescriber Information

Prescriber Name: _________________________________

Prescriber DEA/NPI **(required)**: _____________________

Prescriber Phone #: _______________________________

Prescriber Fax #: _________________________________

Prescriber Address: _______________________________

State: ________________ Zip Code: __________________

Primary Diagnosis: _______________________________ ICD Code: _______________________________________

Please indicate which drug and strength is being requested:

- ☐ Ambien 5mg
- ☐ Ambien 10mg
- ☐ Ambien CR 6.25mg
- ☐ Ambien CR 12.5mg
- ☐ Edluar 5mg Sublingual Tablet
- ☐ Edluar 10mg Sublingual Tablet
- ☐ Intermezzo 1.75 mg Sublingual Tablet
- ☐ Intermezzo 3.5 mg Sublingual Tablet
- ☐ Lunesta 1mg
- ☐ Lunesta 2mg
- ☐ Lunesta 3mg
- ☐ Rozerem 8mg
- ☐ Silenor 3mg
- ☐ Silenor 6mg
- ☐ Sonata 5mg
- ☐ Sonata 10mg
- ☐ Zolpimist 5mg/actuation Oral Spray

Directions for use (i.e. QD, BID, PRN & Qty):____

Please complete the clinical assessment:			
1. Is the patient currently taking the requested medication? If yes, for how long? ____	☐ Yes	☐ No	☐ N/A
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: ☐ Requested medication covered under previous insurance plan ☐ Started medication in hospital ☐ Other: ____	☐ Yes	☐ No	☐ N/A
3. Does the patient have difficulty swallowing OR is the patient unable to swallow tablets?	☐ Yes	☐ No	☐ N/A
4. Does the patient have a documented history of addiction to controlled substances?	☐ Yes	☐ No	☐ N/A

5. Does the patient have middle-of-the-night awakening followed by difficulty returning to sleep?	☐ Yes	☐ No	☐ N/A
6. Has the patient tried zolpidem IR, zolpidem ER, or zaleplon? If yes, please indicate which sedative hypnotic patient has tried: ____________________ ____	☐ Yes	☐ No	☐ N/A

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

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Prescriber Signature: ____Date: _____________________

Office Contact Name: ____________________________ Phone Number: ___________________________

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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