Prior Authorization Request Form for Sedative Hypnotics

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

For Controlled Substances: Did the prescriber or prescriber's delegate search the Pennsylvania Prescription Drug Monitoring Program (PDMP) to review the member's controlled substance prescription history before issuing this prescription for the requested agent?	☐ Yes ☐ No *Submit documentation.*
Requests for all non-preferred Sedative Hypnotics: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Sedative Hypnotics? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No *Submit documentation of previous trials/failures, contraindications, and/or intolerances.*

CHECK ALL THAT APPLY. *SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.*

Therapeutic Duplication:

- ☐ For therapeutic duplication of a benzodiazepine, one of the following:
  - ☐ Is being titrated to or tapered from another benzodiazepine
  - ☐ Has medical reason for concomitant use of benzodiazepines is supported by national treatment guidelines or medical peer-review medical literature
- ☐ Member has filled **2 or more prescriptions for <u>any</u>** benzodiazepine in the past 30 days, both of the following:
  - ☐ The multiple prescriptions are consistent with medically accepted prescribing practices and standard of care, including support from peer-reviewed medical literature or national treatment guidelines
  - ☐ The prescriptions were prescribed by the same prescriber
  - ☐ The prescriptions were prescribed by different prescribers
    - ☐ All prescribers are aware of the other benzodiazepine prescription

Exceeds Quantity Limit:

- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

UNDER 21 YEARS OR AGE:

- ☐ Member has one of the following diagnosis – specify all that apply:
  - ☐ Seizure Disorder
  - ☐ Chemotherapy Induced Nausea/Vomiting
  - ☐ Cerebral Palsy

- ☐ Spastic Disorder
- ☐ Dystonia
- ☐ Catatonia
- ☐ Receiving Palliative Care

NON-24 HOUR SLEEP-WAKE DISORDER:

- ☐ Both of the following:
  - ☐ Is totally blind (has no light perception)
  - ☐ One of the following:
    - ☐ Documented history of therapeutic failure of a 6-month trial of melatonin
    - ☐ Documented contraindication or intolerance to melatonin

NON-PREFERRED SEATIVE HYPNOTIC:

- ☐ Both of the following:
  - ☐ FDA approved or medically accepted indication
  - ☐ Documented history of therapeutic failure, contraindication or intolerance to the preferred Sedative Hypnotic (medication, start and end date):_____

NON-PREFERRED CONTROLLED-RELEASE SEATIVE HYPNOTIC:

- ☐ Documented history of therapeutic failure of the same regular-release Sedative Hypnotic (medication, start and end date):_____

CONCURRENTLY USE OF BUPRENORPHINE AGENT FOR OPIOID DISORDER:

- ☐ The prescriptions were prescribed by the same prescriber
- ☐ The prescriptions were prescribed by different prescribers
  - ☐ All prescribers are aware of the other benzodiazepine prescription
- ☐ Has an **acute** need for the request Sedative Hypnotic controlled substance-specify:_____

RENEWAL REQUEST:

- ☐ Documentation of tolerability and a positive clinical response to the medication:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION:

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)