



# Prior Authorization Request Form for Sedative Hypnotics

FAX this completed form to (844) 205-3386

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

OR Prior authorization may be completed at <https://www.covermyeds.com/main/prior-authorization-forms/>

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:		Member Name:	
Prescriber Specialty:		Identification #:	
NPI:		Group #:	
Office Contact 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:	
<b>IV. REQUIRED DOCUMENTATION (Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)</b>			
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?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
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 <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes <input type="checkbox"/> No Medications Tried: _____ _____ _____	
<b>CHECK ALL THAT APPLY. SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.</b>			
<b>Therapeutic Duplication:</b>			
<input type="checkbox"/> For therapeutic duplication of a benzodiazepine, one of the following:			
<input type="checkbox"/> Is being titrated to or tapered from another benzodiazepine			
<input type="checkbox"/> Has medical reason for concomitant use of benzodiazepines is supported by national treatment guidelines or medical peer-review medical literature; reasoning: _____			
<input type="checkbox"/> Member has filled <b>2 or more prescriptions for any</b> benzodiazepine in the past 30 days, both of the following:			
<input type="checkbox"/> 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; reasoning _____			
<input type="checkbox"/> The prescriptions were prescribed by the same prescriber			
<input type="checkbox"/> The prescriptions were prescribed by different prescribers			
<input type="checkbox"/> All prescribers are aware of the other benzodiazepine prescription			
<b>Exceeds Quantity Limit:</b>			
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to <a href="https://www.pahealthwellness.com/providers/pharmacy.html">https://www.pahealthwellness.com/providers/pharmacy.html</a> under PHW Quantity Limit List), please provide supporting information: _____			
<b>UNDER 21 YEARS OR AGE:</b>			
<input type="checkbox"/> Member has one of the following diagnosis – specify all that apply:			
<input type="checkbox"/> Seizure Disorder			
<input type="checkbox"/> Chemotherapy Induced Nausea/Vomiting			
<input type="checkbox"/> Cerebral Palsy			

- Spastic Disorder
- Dystonia
- Catatonia
- Receiving Palliative Care

**NON-24 HOUR SLEEP-WAKE DISORDER:**

- One of the following:
  - Documented history of therapeutic failure of a 6-month trial of melatonin
  - Documented contraindication or intolerance to melatonin

**NON-PREFERRED SEDATIVE 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 SEDATIVE 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:
--	---------------------	-------

Pharmacy Department 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.)