



## Ambien® (zolpidem) & Ambien CR® (zolpidem extended-release [ER]) Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Insomnia <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<p><i>The approval criteria is based on the guidance provided by the Centers for Medicare &amp; Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare &amp; Medicaid Services Physician Quality Reporting System.</i></p> <p>Please note: Medication is considered high risk when used longer than 90 days.</p> <p><b>Risk acknowledgment:</b>            Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? <input type="checkbox"/> Yes <input type="checkbox"/> No            Does the provider wish to proceed with the originally prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p><b>Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.</b></p> <p><b>Select the medications the patient has a failure, contraindication, or intolerance to:</b></p> <input type="checkbox"/> Belsomra <input type="checkbox"/> Zaleplon <input type="checkbox"/> Eszopiclone <input type="checkbox"/> Zolpidem <input type="checkbox"/> Rozerem <input type="checkbox"/> Zolpidem ER <input type="checkbox"/> Trazodone					
<p><b>Medication use beyond 90 days:</b>            Will the patient be using the requested medication beyond 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No            Does the provider attest that the benefits outweigh the risks of using this high risk medication for more than 90 days in a 365 day period in patients age 65 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p><b>Quantity limit requests:</b>            What is the quantity requested per DAY? _____</p> <p><b>What is the reason for exceeding the plan limitations?</b></p> <input type="checkbox"/> Titration or loading-dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. <b>Please specify:</b> _____ <input type="checkbox"/> Other: _____					



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

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Please note:

This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.