

Newer Sedative Hypnotics Prior Authorization Request Form



5589

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) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

PLEASE NOTE:

- **NO prior authorization is required for zolpidem immediate-release tablet (Ambien).**
- Prior authorization for the non-preferred agents zolpidem ER (Ambien CR), Edluar, Lunesta, Rozerem, Silenor, Sonata, or Zolpimist is **NOT** required for patients who are currently receiving these medications **based on prescriptions filled during the last 6 months, or if there has been a trial of the preferred agent zolpidem immediate-release tablet based on prescriptions filled during the last 6 months.**

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> • The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477 • The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TpharmPA@express-scripts.com
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Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php

Drug for which Prior Authorization is requested:	<input type="checkbox"/> Ambien CR (zolpidem ER tablet)	<input type="checkbox"/> Rozerem (ramelteon)
	<input type="checkbox"/> Edluar (zolpidem sublingual tablet)	<input type="checkbox"/> Silenor (doxepin)
	<input type="checkbox"/> Lunesta (eszopiclone)	<input type="checkbox"/> Sonata (zaleplon)
		<input type="checkbox"/> Zolpimist (zolpidem oral spray)

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. Has the patient received a trial of zolpidem immediate-release tablet (Ambien) and had an inadequate response?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 2
2. Has the patient received a trial of zolpidem immediate-release tablet (Ambien), but was unable to tolerate it due to adverse effects?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 3
3. Is treatment with zolpidem immediate-release tablet (Ambien) contraindicated for this patient (e.g., due to hypersensitivity)?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 4
4. Is the medication being prescribed Rozerem or Silenor?	<input type="checkbox"/> Yes Proceed to Question 5	<input type="checkbox"/> No Proceed to Question 6
5. Is Rozerem or Silenor considered to be the most clinically suitable choice for this patient due to its apparent lack of abuse potential?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Coverage not approved
6. Is the requested medication Edluar or Zolpimist AND the patient has swallowing difficulties?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

<div style="display: flex; justify-content: space-between;"> </div>	<div style="display: flex; justify-content: space-between;"> </div>
Prescriber Signature	Date