AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Sedative Hypnotics

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __Other:____ (Max length of therapy is 180 days)

Clinical Information

For Non-Preferred Drugs:

1. Failed two (2) preferred drugs. List preferred drugs failed: _____
1a. __Allergic reaction 1b. __ Drug-to-drug interaction. Please describe reaction: _____
_____
2. Previous episode of an unacceptable side effect or therapeutic failure with preferred drug(s). Please provide clinical information: _____
3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provide clinical information: _____
4. Age specific indication for non-preferred agent. Please give beneficiary age and explain:_____
5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference:
_____
6. Unacceptable clinical risk associated with therapeutic failure. Please explain: _____
_____

Criteria for Quantity Limits: Exceeding Quantity of 15 per 30 days (check all that apply)

1. Does beneficiary have a diagnosis of chronic primary insomnia lasting one month or longer? Yes___ No___
2. Has beneficiary received information on good sleep hygiene and had a documented trial (at least 3 weeks) of non-pharmacological therapies (ex. stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy)?
Yes___ No___
3. Does beneficiary have diagnosis of chronic secondary or co-morbid insomnia lasting one month or longer and has been evaluated for and is being actively treated for one of the below conditions? Yes___ No___
Please check appropriate condition: ☐ **a.** underlying psychiatric illness associated with insomnia
☐ **b.** underlying medical illness associated with insomnia (ex. chronic pain associated with cancer, inflammatory arthritis etc.)
☐ **c.** sleep disorder such as restless legs syndrome, sleep-related breathing disorder, sleep related movement disorder, or circadian rhythm disorder
4. Is beneficiary being discontinued from a sedative hypnotic and tapering is required to prevent symptoms of withdrawal?
Yes___ No___
5. Is beneficiary being actively assessed for a diagnosis of chronic primary or secondary/co-morbid insomnia? Yes___ No___
(Do not check "yes" if answer to #1 above is "yes")

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406