INSOMNIA AGENTS
PRIOR AUTHORIZATION / MEDICAL NECESSITY DETERMINATION
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

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PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient diagnosis (ICD code and description):

Medication requested: Strength:

Dosing schedule: Quantity per month:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
2. Are there medical records of the patient's medication history showing the use of TWO prerequisite agents (i.e., eszopiclone, zaleplon , zolpidem) within the past 90 days? **Medical records are required.** ☐ Yes ☐ No
   If no, is there a MedWatch form (http://fda.gov/media/76299/download) showing the patient has an intolerance or hypersensitivity to TWO prerequisite agents (i.e., eszopiclone, zaleplon , zolpidem)? **MedWatch form is required.** ☐ Yes ☐ No
   If no, are there medical records showing the patient has an FDA labeled contraindication to ALL prerequisite agents (i.e., eszopiclone, zaleplon , zolpidem)? **Medical records are rquired.** ☐ Yes ☐ No
3. Are there medical records showing the requested agent is a non-controlled agent AND the patient requires therapy with a non-controlled agent (Silenor, doxepin, ramelteon, or Rozerem)? **Medical records are required.** ☐ Yes ☐ No
4. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested diagnosis? ☐ Yes ☐ No
   If yes, please provide information to support therapy with a higher quantity (dose) for the requested diagnosis: _____
   _____
   If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit? ☐ Yes ☐ No
   If no, please explain why the requested dose cannot be optimized: _____
   _____

Please fax or mail this form to:
Horizon Blue Cross Blue Shield of New Jersey
c/o Prime Therapeutics LLC, Clinical Review Department
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Eagan, MN 55121

TOLL FREE
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