CAREFIRST - DC EXCHANGE 5T
Dayvigo (HMF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Dayvigo (HMF).

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Dayvigo (lemborexant)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the treatment of insomnia characterized by difficulties with sleep onset and/or sleep maintenance?	**Y** ☐	**N** ☐
2.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
3.	Has the patient achieved or maintained a positive response to treatment from baseline?	**Y** ☐	**N** ☐
4.	Has the patient's need for continued therapy been assessed?	**Y** ☐	**N** ☐
5.	Do potential factors contributing to sleep disturbances continue to be addressed (e.g., inappropriate sleep hygiene, sleep environment issue, treatable medical/psychiatric comorbid disorders)?	**Y** ☐	**N** ☐
6.	Does the patient require MORE than the plan allowance of 30 tablets per month of any of the following: A) Belsomra (suvorexant), B) Dayvigo (lemborexant), C) Quviviq (daridorexant)?	**Y** ☐	**N** ☐
7.	Have potential factors contributing to sleep disturbances been addressed or are currently being addressed (e.g., inappropriate sleep hygiene and sleep environment issues) as well as treatable medical/psychiatric disorders that are co-morbid with insomnia?	**Y** ☐	**N** ☐
8.	Is the patient 65 years of age or older?	**Y** ☐	**N** ☐
9.	Has the patient experienced an inadequate treatment response to ANY of the following: A) a generic non-benzodiazepine sedative-hypnotic (e.g., eszopiclone, zaleplon, zolpidem), B) a benzodiazepine (e.g., temazepam)?	**Y** ☐	**N** ☐

10.	Has the patient experienced an intolerance to ANY of the following: A) a generic non-benzodiazepine sedative-hypnotic (e.g., eszopiclone, zaleplon, zolpidem), B) a benzodiazepine (e.g., temazepam)?	**Y** ☐	**N** ☐
11.	Does the patient have a contraindication that would prohibit a trial of ALL of the following: A) a generic non-benzodiazepine sedative-hypnotic (e.g., eszopiclone, zaleplon, zolpidem), B) a benzodiazepine (e.g., temazepam)?	**Y** ☐	**N** ☐
12.	Does the patient require MORE than the plan allowance of 30 tablets per month of any of the following: A) Belsomra (suvorexant), B) Dayvigo (lemborexant), C) Quviviq (daridorexant)?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date