BlueCross BlueShield Federal Employee Program

SEDATIVE HYPNOTICS PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the provider portion and submit this completed form.

Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

Sedative Hypnotics

NOTE: Form must be completed in its **entirety** for processing

Please Select Medication:	Please Select Strength:
❑Ambien (zolpidem)	❑5mg ❑10mg
❑Ambien CR (zolpidem)	❑6.25mg ❑12.5mg
❑Dalmane (flurazepam)	❑15mg ❑30mg
❑Doral (quazepam)	❑15mg
❑Edluar (zolpidem SL)	❑5mg ❑10mg
❑Halcion (triazolam)	❑0.125mg ❑0.25mg
❑Intermezzo (zolpidem SL)	❑1.75mg ❑3.5mg
❑Lunesta (eszopiclone)	❑1mg ❑2mg ❑3mg
❑Prosom (estazolam)	❑1mg ❑2mg
❑Restoril (temazepam)	❑7.5mg ❑15mg ❑22.5mg ❑30mg
❑Sonata (zaleplon)	❑5mg ❑10mg
❑Zolpidem capsule	❑7.5mg
❑Zolpimist (zolpidem)	❑5mg oral spray

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

*****Non-covered branded medications must go through prior authorization and the formulary exception process**

Is this request for brand or generic? ❑Brand ❑Generic

How many canisters/capsules/tablets will the patient need for a 90 day supply? _____ can(s)/cap(s)/tab(s) per 90 days

What are the dosing directions? _____

1. What is the patient's diagnosis?
   ❑Insomnia
   ❑Persistent disorder of initiating or maintaining sleep
   ❑Other diagnosis ***(please specify)***: _____ ***(answer the following question)***
   a. Is this diagnosis causing the patient to have a persistent disorder of initiating or maintaining sleep? ❑Yes ❑No
2. Does the prescriber agree to discontinue the sedative hypnotic if the patient experiences a complex sleep behavior, such as sleep-walking or sleep-driving? ❑Yes ❑No
3. Will this medication be used in combination with another Prior Authorization (PA) sleep aid or with an oxybate product such as Xyrem or Xywav? Yes***** ❑No
   ****If YES,*** please specify the medication: _____

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Sedative Hypnotics – FEP MD Fax Form Revised 6/13/2025