

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 Inform Date:	Provider Information (required) 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:			Physician S	ignature:			
PHYSICIAN COMPLETES							
Sedative Hypnotics							
NOTE: Form must be completed in its entirety for processing Please Select Medication: Please Select Strength:							
☐ Ambien (zolpidem)			□5mg	1 Strength: □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	□22.5r	ng 🗆	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?							
 What is the patient's diagnosis? □Insomnia □Persistent disorder of initiating 		sleep					
☐Other diagnosis (please specif				(answer the	e 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 Xyrem or Xyway? Yes* □N		another Prior	Authorization	(PA) sleep aid	d or with	an oxybat	te product such as

*If YES, please specify the medication: _