



2018 zolpidem tartrate (generic Ambien®) immediate release tablets Prior Authorization Request

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(You must complete both pages.)

Coverage criteria for patients age 65 or older:

- Short-term treatment of insomnia characterized by difficulties with sleep initiation OR
- Long-term treatment of insomnia OR
- Insomnia due to selective serotonin re-uptake inhibitor (SSRI) adverse reaction AND
- The prescriber acknowledges that the medication benefits outweigh potential risks in members 65 years of age or older
- Authorization period: Remainder of contract year. Note: members under 65 years of age are not subject to the prior authorization requirements

Fax completed form to: 1-800-408-2386

For urgent requests, please call: 1-800-414-2386

Patient information		Prescriber information	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		M.D. office telephone number	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient date of birth	M.D. office fax number	
Diagnosis and medical information			
Medication requested <input type="checkbox"/> zolpidem tartrate (generic Ambien®) immediate release tablet		Strength and route of administration	Frequency
New prescription OR date therapy initiated		Quantity	Day supply
Expected length of therapy			
Diagnosis (Please check all boxes that apply and include all office notes supporting diagnosis.)			
<input type="checkbox"/> Insomnia, short-term treatment		<input type="checkbox"/> Insomnia, long-term treatment	
<input type="checkbox"/> Insomnia, selective serotonin re-uptake inhibitor (SSRI) adverse reaction			
<input type="checkbox"/> Other diagnosis/(ICD 10): _____			
Please check all boxes that apply:			
1. <input type="checkbox"/> Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result in adverse clinical outcomes.			
2. <input type="checkbox"/> All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.			
3. The American Geriatric Society recommends avoiding high risk medications (HRM) in the elderly as a safety concern. To ensure safe use of potentially high risk medications (HRM) in the elderly population, prescriber must acknowledge that medication benefits outweigh potential risks in the elderly. Note: Members under 65 years of age are not subject to the prior authorization requirements. <input type="checkbox"/> The requested medication is medically necessary and the clinical benefits outweigh the risks for this specific patient.			
4. <input type="checkbox"/> Yes <input type="checkbox"/> No The quantity limit for zolpidem tartrate immediate release tablet is 30 tablets per 30 days. Does patient require higher dosage (quantity limit exception)? ▶ If yes, indicate quantity requested: _____ per 30 days OR quantity _____ per day <input type="checkbox"/> The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition. <input type="checkbox"/> The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.			

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Please check all boxes that apply (continued):

5. Please list all medications the patient has tried specific to the diagnosis and specify below.

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

6. Other supporting information

*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

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 documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	Date
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