aetna™

2020 Zolpidem Tartrate Immediate Release (generic Ambien®) Prior Authorization Request

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(You must complete both pages.)

Please fax completed form to: 1-800-408-2386 For urgent requests, please call: 1-800-414-2386

Coverage criteria:

- This prior authorization is to ensure safe use of a potentially high risk medication in the elderly population and only applies to patients 65 years of age or older who have had greater than 90 days of cumulative therapy with zolpidem per year. Patients under 65 years of age and patients who have NOT had greater than 90 days of cumulative therapy with zolpidem per year are not subject to the prior authorization requirements.
- Medication is covered when being prescribed for the short-term treatment of insomnia characterized by difficulties with sleep initiation **AND**
- Patient has tried and has had an inadequate treatment response or intolerance to the non-high risk medication (HRM) alternative drug Silenor (3mg or 6mg) OR the patient has a contraindication to the non-high risk medication (HRM) alternative drug Silenor (3mg or 6mg) **AND**
- **Prescriber has acknowledged that medication benefits outweigh potential risks in patients 65 years of age or older.**

Authorization duration: Through end of plan contract year

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 ☐ Male ☐ Female	Patient date of birth	M.D. office fax number		
Diagnosis and medical information				
Medication requested ☐ zolpidem tartrate immediate release 5mg tablet ☐ zolpidem tartrate immediate release 10mg 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.)*

☐ Short-term treatment of insomnia characterized by difficulties with sleep initiation

☐ Other diagnosis/(ICD 10): _____

Please check all boxes that apply:

1. ☐ **Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result in adverse clinical outcomes.**
2. ☐ **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.**

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Please check all boxes that apply (continued):

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.)*

☐ The requested medication is medically necessary and the clinical benefits outweigh the risks for this specific patient.

4. ☐ **Yes** ☐ **No** **Has the patient had greater than 90 days of cumulative therapy with zolpidem per year?**

☐ **Yes** ☐ **No** **Will the patient require more than 90 days of cumulative therapy with zolpidem in the 2020 calendar year?**

5. ☐ **Yes** ☐ **No** **Has the patient tried the non-high risk medication (HRM) alternative drug Silenor (3mg or 6mg)?**

☐ **Yes** ☐ **No** **Has the patient had an inadequate treatment response OR intolerance to the non-high risk medication (HRM) alternative drug Silenor (3mg or 6mg)?**

☐ **Yes** ☐ **No** **Does the patient have a contraindication to the non-high risk medication (HRM) alternative drug Silenor (3mg or 6mg)?**

6. ☐ Yes ☐ 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**

☐ 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.

☐ 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.

7. ☐ **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

8. ☐ **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**