PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Ambien® (zolpidem) & Ambien CR® (zolpidem extended-release [ER]) Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Insomnia
❑ Other diagnosis:______________________________ICD-10 Code(s): ____________________________________

The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

Please note: Medication is considered high risk when used longer than 90 days.

Risk acknowledgment:

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? ❑ **Yes** ❑ **No**

Does the provider wish to proceed with the originally prescribed medication? ❑ **Yes** ❑ **No**

Please document the intended duration of therapy: ____

Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Belsomra ❑ Trazodone
❑ Eszopiclone ❑ Zaleplon
❑ Rozerem ❑ Zolpidem tablet

For patients who have or will exceed the plan limit of a 90 day supply in a 365 day period:

Explain medical reasons why more than the plan limit is needed:____**AND**

Provide medical/scientific evidence you have to support safe use of this high risk medication for more than 90 days in patients age 65 and older:____

Quantity limit requests:

What is the quantity requested per DAY? _______

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _______________________________________
❑ Other:____

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Prior Authorization Request Form (Page 2 of 2)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): ______________________________ **Date:** ______________

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	

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