CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Insomnia Agents (FA-EXC) – Prior Authorization Request

Send completed form to: CVS/caremark Fax: 888-487-9257

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-487-9257**. Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Insomnia Agents (FA-EXC).

Patient Name:	**Date**:
Patient's ID:	**Patient's Group #:**
Patient's Date of Birth:	**Patient's Phone:**
Physician's Name:	
Physician's Address:	
Specialty:	**NPI #:**
Physician Office Telephone:	**Physician Office Fax:**

1. What drug is being prescribed? ☐ Intermezzo (zolpidem) ☐ Lunesta (eszopiclone) ☐ Rozerem (ramelteon) ☐ Other _____

   Quantity: _____ Frequency: _____ Strength: _____

   Route of administration: _____ Expected Length of Therapy: _____

2. What is the patient's diagnosis? _____

3. What is the ICD code? _____

4. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? ☐ Yes ☐ No

5. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below? ☐ Yes ☐ No (If yes, no further questions – please document drug name, trial year and reason for failure.) _____
   _____
   _____

   Requirement: 3 in a class with 3 alternatives: eszopiclone, zolpidem, zolpidem ext-rel, Silenor

6. Does the patient have a documented clinical reason such as expected adverse reaction or contraindication that prevents them from trying the formulary alternatives listed below? ☐ Yes ☐ No (If yes, please document the reason(s) the patient cannot try the formulary alternatives.) _____
   _____
   _____

   Formulary alternatives: eszopiclone, zolpidem, zolpidem ext-rel, Silenor

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date: (mm/dd/yy)**

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