Iowa Medicaid
IOWA HHS

Request for Prior Authorization

SEDATIVE/HYPNOTICS-NON-BENZODIAZEPINE

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits.

PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with, at a minimum, three (3) preferred agents. Payment for non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2) A diagnosis of insomnia, 3) Medications with a side effect of insomnia are decreased in dose, changed to a short acting product, and/or discontinued, 4) Enforcement of good sleep hygiene is documented, 5) All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses. 6) Will not be used concurrently with a benzodiazepine sedative/hypnotic agent. 7) In addition to the above criteria, requests for an orexin receptor antagonist will require documentation of a trial and therapy failure with at least one non-preferred agent prior to consideration of coverage. 8) Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

- ☐ Eszopiclone
- ☐ Zaleplon
- ☐ Zolpidem

Non-Preferred

- ☐ Ambien
- ☐ Ambien CR
- ☐ Belsomra
- ☐ Dayvigo
- ☐ Edluar
- ☐ Lunesta
- ☐ Quviviq
- ☐ Ramelteon
- ☐ Rozerem
- ☐ Zolpimist
- ☐ Zolpidem Caps
- ☐ Zolpidem ER
- ☐ Zolpidem SL Tab

Strength _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

Diagnosis_____ **Date of Diagnosis:** _____

Co-Morbid Conditions Contributing to Insomnia: _____
_____

Non-Pharmacological Treatments Tried: _____

Requests for Non-Preferred Drugs:

Eszopiclone Trial: Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Zaleplon Trial: Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Zolpidem Trial: Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

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Will requested agent be used concurrently with a benzodiazepine sedative/hypnotic?

☐ Yes Drug Name: _____ ☐ No

Requests for Orexin Receptor Antagonist (in addition to three (3) trials above):

Trial of Non-Preferred Agent: Drug Name & Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Medical Necessity for alternative delivery system: _____

Reason for use of Non-Preferred drug requiring prior approval: _____

_____

Attach lab results and other documentation as necessary (Required).

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*