Sedative/Hypnotic
Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that members receiving a sedative/hypnotic must meet the agent criteria located on the Preferred Drug List (PDL), located on the North Dakota Department of Human Services Prior Authorization website at http://www.hidesigns.com/ndmedicaid.

Note:

- **Requires step therapy. See Sedative/Hypnotic PA criteria for more information.**
  - Zolpidem: Initiation with trial of 5 mg must be used for 7 days within 90 days prior to 10 mg tablets
  - Belsomra: The member must have had a 25- day trial of eszopiclone within the past 90 days

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Member Medicaid ID Number
Prescriber Name		
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**Diagnosis for this request:**	

Qualifications for coverage:

List all failed medications:	**Start Date:**	**End Date:**

Have other conditions causing sleep issues been ruled out?	☐ YES ☐ NO
Does the member require dose tapering?	☐ YES ☐ NO
Is the member's insomnia characterized by difficulty with sleep maintenance?	☐ YES ☐ NO
Is the member's insomnia characterized by difficulty with sleep initiation?	☐ YES ☐ NO
Is the member's insomnia characterized by difficulty with middle of the night awakening with more than 4 hours left to sleep?	☐ YES ☐ NO
Is the member blind in both eyes? (For non-24 hour sleep-wake disorder)	☐ YES ☐ NO

☐ I *confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the member.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #