health information designs

# 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 patients receiving a new prescription for a name brand Sedative/Hypnotic must use Ambien® (zolpidem) as first line therapy.

*__Note:__

- **Requires step therapy. See Sedative/Hypnotic PA criteria for more information.**

**Part I: TO BE COMPLETED BY PHYSICIAN**

| | | | |
|---|---|---|---|
| Recipient Name | Recipient Date of Birth | Recipient Medicaid ID Number | |
| Prescriber Name | | | |
| Prescriber NPI | Telephone Number | Fax Number | |
| Address | City | State | Zip Code |
| **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 patient require dose tapering? | □ YES □ NO |
| Is the patient's insomnia characterized by difficulty with sleep maintenance? | □ YES □ NO |
| Is the patient's insomnia characterized by difficulty with sleep initiation? | □ YES □ NO |
| Is the patient's insomnia characterized by difficulty with middle of the night awakening with more than 4 hours left to sleep? | □ 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 recipient.*

| | |
|---|---|
| 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 patient'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 # |