Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Insomnia Agents Post Limit

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 **1-888-836-0730**.
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 Post Limit.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the drug being prescribed for insomnia?	Y N
2.	Have potential causes of sleep disturbances been addressed (e.g., inappropriate sleep hygiene and sleep environment issues or treatable medical/psychological causes of chronic insomnia)?	Y N
3.	Is the request for Sonata (zaleplon)?	Y N
	[If no, then skip to question 5.]	
4.	Does the patient require use of MORE than 60 capsules per month of Sonata (zaleplon)?	Y N

5.	Does the patient require use of MORE than any of the following: A) 30 tablets per month of Ambien (zolpidem), Ambien CR (zolpidem extended-release), Lunesta (eszopiclone), or Rozerem (ramelteon), B) 15 tablets/capsules per month of flurazepam, Doral (quazepam), estazolam, Restoril (temazepam), C) 10 tablets per month of Halcion (triazolam)?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date