carolina complete health

Pharmacy Prior Approval Request
Sedative Hypnotics

Member Information

1. Member Last Name:		2. Member First Name:	
3. Member ID#:		4. Member Date of Birth:	
5. Member Gender:			

Prescriber Information

6. Provider NPI#:		7. Provider Last Name:	
8. Requestor Contact Name:		9. Requestor Contact Phone# and Extension:	

Drug Information

10. Drug Name:		11. Drug Strength:	
12. Quantity per 30 days:		13. Length of Therapy:	☐Up to 30 days ☐60 ☐90
			☐120 ☐180 ☐other_________

Clinical Information

Request for Non-Preferred Drug

☐ Failed two (2) preferred drugs. If only one (1) is available, then failed one preferred drug.	List preferred drugs failed, and reason failed (if allergic reaction or drug to drug interaction, please describe):
☐ Previous episode of an unacceptable side effect or therapeutic failure with preferred drug(s).	Please provide clinical information:
☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug (s).	Please provide clinical information:
☐ Age specific indications for non-preferred agent.	Please give member age and explain:
☐ Unique clinical indication supported by FDA approval or peer reviewed literature.	Please explain and provide a reference:
☐ Unacceptable clinical risk associated with therapeutic failure.	Please explain:

Criteria for Exceeding Quantity Limits of 15 per 30 days (check all that apply)

1. Does member have a diagnosis of chronic primary insomnia lasting one month or longer? ☐ Yes ☐ No	2. Has member received information on good sleep hygiene and had a documented trial (at least 3 weeks) of non-pharmacological therapies (ex. stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy)? ☐ Yes ☐ No

Continued on next page

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3. Does member have diagnosis of chronic secondary or co-morbid insomnia lasting one month or longer and has been evaluated for and is being actively treated for one of the below conditions? ☐ Yes ☐ No Please check appropriate condition: ☐a. underlying psychiatric illness associated with insomnia ☐b. underlying medical illness associated with insomnia (ex chronic pain associated with cancer, inflammatory arthritis etc.) ☐c. sleep disorder such as restless legs syndrome, sleep-related breathing disorder, sleep related movement disorder, or circadian rhythm disorder	4. Is member being discontinued from a sedative hypnotic and tapering is required to prevent symptoms of withdrawal? ☐ Yes ☐ No 5. Is member being actively assessed for a diagnosis of chronic primary or secondary/co-morbid insomnia? ☐Yes ☐ No (Do not check "yes" if answer to #1 above is "yes")
6. Is the member being discontinued from a sedative hypnotic and tapering is required to prevent symptoms of withdrawal? ☐ Yes ☐ No	

Signature of Prescriber: ____________________________________ Date: _________

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.