HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

CHRONIC INSOMNIA MEDICATIONS

Belsomra®, Dayvigo®, Rozerem®, doxepin

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Belsomra® (suvorexant), ☐ Dayvigo®(lemborexant), ☐ Rozerem® (ramelteon), ☐ doxepin (3mg, 6mg)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Has the member been diagnosed with chronic insomnia?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. Does the member have functional distress or impairment caused by poor sleep?	☐	☐	**Please provide documentation**
4. Has the member experienced poor sleep for at least 3 nights per week for at least 3 months?	☐	☐	**Please provide documentation**
5. Is the sleep disorder related to medication or other mental disorders?	☐	☐	**Please provide documentation**
6. Have the following causes been ruled out: obstructive sleep apnea, chronic obstructive pulmonary disease, depression and anxiety?	☐	☐	**Please provide documentation**
7. Has the member had cognitive behavioral therapy to treat insomnia for at least 3 months?	☐	☐	**Please provide documentation**
8. Has the member had at least a 3-month trial and failure of, or contraindication to, over-the-counter sleep aids (e.g. melatonin, diphenhydramine, or doxylamine)?	☐	☐	**Please provide documentation**
9. Has the member had at least a 3-month trial and failure of, or contraindication to at least one generic antidepressant (e.g. amitriptyline, trazodone, etc.)?	☐	☐	**Please provide documentation**

10. Has the member had at least a 3-month trial and failure of, or contraindication to at least 1 generic non-benzodiazepine hypnotic medication (e.g. zolpidem, zaleplon, eszopiclone)?	☐	☐	**Please provide documentation**
11. If the request is for Belsomra® (suvorexant), has the member tried and failed, or have a contraindication/intolerance to Dayvigo® (lemborexant)?	☐	☐	**Please provide documentation**
12. If the request is for doxepin 3mg or 6mg, has the member tried and failed generic doxepin 10mg for at least 3-months with an inadequate response?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member meet at least two of the following: • Time to onset of sleep has improved, total time asleep has improved, number of night awakenings reducing quality of sleep has improved	☐	☐	**Please provide documentation**
3. Has the member experienced significant adverse effects from the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-038
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024