

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>			
Pharmacy NPI:		Pharmacy fax:	NDC:

Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. Requests for doses above the manufacturer recommended dose will not be considered.

Prior authorization is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of a previous trial and therapy failure with, at a minimum, three (3) preferred agents. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be considered when the following criteria are met: 1) A diagnosis of insomnia, 2) Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued, 3) Enforcement of good sleep hygiene is documented, 4) All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses. 5) In addition to the above criteria, requests for suvorexant (Belsomra) will require documentation of a trial and therapy failure with at least one non-preferred agent, other than suvorexant, prior to consideration of coverage. 6) Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult [www.iowamedicaidpdl.com/pa\\_criteria](http://www.iowamedicaidpdl.com/pa_criteria).

**Preferred:**

**Non-Preferred:**

- |                                      |                                    |                                     |                                      |                                    |
|--------------------------------------|------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Eszopiclone | <input type="checkbox"/> Ambien    | <input type="checkbox"/> Edluar     | <input type="checkbox"/> Rozerem     | <input type="checkbox"/> Zolpimist |
| <input type="checkbox"/> Zaleplon    | <input type="checkbox"/> Ambien CR | <input type="checkbox"/> Intermezzo | <input type="checkbox"/> Sonata      |                                    |
| <input type="checkbox"/> Zolpidem    | <input type="checkbox"/> Belsomra  | <input type="checkbox"/> Lunesta    | <input type="checkbox"/> Zolpidem ER |                                    |

Strength: \_\_\_\_\_ Quantity: \_\_\_\_\_ Days Supply: \_\_\_\_\_

Dosage Instructions: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Co-Morbid Conditions Contributing to Insomnia:

\_\_\_\_\_

Non-Pharmacological Treatments Tried:

\_\_\_\_\_

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**Requests for Non-Preferred Drugs:**

**Eszopiclone Trial:**

Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Zaleplon Trial:**

Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Zolpidem Trial:**

Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

**Requests for Belsomra (in addition to three (3) trials above):**

**Trial of Non-Preferred Agent:**

Drug Name & Dose: \_\_\_\_\_ Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Reason for Failure: \_\_\_\_\_

Medical Necessity for alternative delivery system: \_\_\_\_\_

Reason for use of Non-Preferred drug requiring prior approval: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature:  
(Must match prescriber listed above.)

Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check [www.amerihealthcaritasia.com/Provider](http://www.amerihealthcaritasia.com/Provider) to confirm your version of this form.