

TRICARE Prior Authorization Request Form for
 suvorexant (**Belsomra**), lemborexant (**Dayvigo**), daridorexant (**Quviviq**)



JOHNS HOPKINS
 MEDICINE

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 HEALTHCARE

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**FAX Completed Form and
 Applicable Progress Notes to:
 (410) 424-4037**

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name: _____	Strength: _____
Dosage/Frequency (SIG): _____	Duration of Therapy: _____

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. The provider acknowledges that the following agents are available without prior authorization: zolpidem IR and ER, zaleplon, eszopiclone.	<input type="checkbox"/> Acknowledged Proceed to question 2	
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.	<input type="checkbox"/> Yes (subject to verification) Proceed to question 3	<input type="checkbox"/> No Proceed to question 6
3. Has the patient adequately responded to non-pharmacologic therapies?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 4
4. Does the patient agree to continue with non-pharmacologic therapies including but not limited to relaxation therapy, cognitive behavioral therapy for insomnia (CBT-I), and/or sleep hygiene?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Does the patient continue to respond to the drug?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
6. Does the patient have a documented diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. Have non-pharmacologic therapies been inadequate in improving functional impairment, including but not limited to, relaxation therapy, cognitive behavioral therapy for insomnia (CBT-I), sleep hygiene, and will the patient continue with non-pharmacologic therapies throughout treatment?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved

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8. Has the patient failed, or had clinically significant adverse effects to zolpidem extended-release OR eszopiclone?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Does the patient have a current or previous history of narcolepsy?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 10
10. Does the patient have a current or previous history of substance and/or alcohol use disorder?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature

_____ Date

[22 June 2022]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: _____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#: