Prior Authorization Request Form for
Edluar (zolpidem sublingual tablet), **Intermezzo** (zolpidem sublingual tablet),
Rozerem (ramelteon), **Silenor** (doxepin), **Zolpimist** (zolpidem oral spray)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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. Has the patient tried zolpidem immediate-release (IR) oral tablet, zaleplon, zolpidem ER, or eszopiclone and had an inadequate response or was unable to tolerate it due to adverse effects?	☐ Yes Sign and date below	☐ No Proceed to question 2
2. Is treatment with zolpidem immediate-release (IR) oral tablet, zaleplon, zolpidem ER, or eszopiclone contraindicated for this patient, for example, due to hypersensitivity, aberrant behaviors, or intolerable rebound insomnia?	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Which medication is requested?	☐ **Edluar, Intermezzo, Zolpimist** – Proceed to question **4**	
	☐ **Rozerem, Silenor** – Proceed to question **5**	
	☐ **All other agents – STOP**: **Coverage not approved**	
4. *(Edluar, Intermezzo, Zolpimist request)* **Does the patient have swallowing difficulties?**	☐ Yes Sign and date below	☐ No Coverage not approved
5. *(Rozerem, Silenor request)* **Is the requested medication the most clinically suitable choice for this patient due to its apparent lack of abuse potential?**	☐ Yes Sign and date below	☐ No Coverage not approved

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

_____ _____
Prescriber Signature Date

[02 August 2017]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: