TRICARE Prior Authorization Request Form for
zolpidem tartrate capsule

USFHP Pharmacy Prior Authorization Form

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

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.

Please note zolpidem 7.5 mg capsules will be completely excluded from the TRICARE pharmacy benefit starting on 2/28/2024, regardless of how long the PA is approved.

No refills allowed; new prescription is required for each fill until complete exclusion status implementation.

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. Provider acknowledges that zolpidem 7.5 mg capsules will be completely excluded from the Tricare Pharmacy Benefit starting on February 28th, 2024, regardless of how long the PA is approved.	☐ Acknowledged Proceed to question **2**
2. Provider acknowledges that generic zolpidem IR 5 mg and 10 mg tabs, zolpidem ER 6.25 mg and 12.5 mg tabs, zaleplon 5 mg and 10 mg caps; and eszopiclone 1 mg, 2 mg and 3 mg tabs are available without requiring PA. Please consider changing the prescription to one of these other products.	☐ Acknowledged Proceed to question **3**
3. Please explain why the patient cannot take any of the drugs listed above, including zolpidem IR 5 mg and 10 mg tabs or zolpidem 6.25 mg or 12.5 mg tabs.	_____ 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

[15 Nov 2023]

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