

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



**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):

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

**Step 2** Please complete the clinical assessment:

1. 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 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Have non-pharmacologic therapies been inadequate in improving functional impairment, including but not limited to, relaxation therapy, cognitive therapy, sleep hygiene?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Has the patient failed, or had clinically significant adverse effects to zolpidem extended-release AND eszopiclone?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
4. Does the patient have a current or previous history of narcolepsy?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 5
5. Does the patient have a current or previous history of drug abuse?	<input type="checkbox"/> Yes <b>STOP</b> 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

[ 27 May 2020 ]

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#:
Date Faxed to MD:	Date Decision Rendered: