Prior Authorization Form

Edluar

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Edluar.

Drug Name (select from list of drugs shown)
Edluar (zolpidem sublingual)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Have potential causes of sleep disturbances been addressed or are currently being addressed (e.g., inappropriate sleep hygiene and sleep environment issues or treatable medical/psychological disorders that are co-morbid with insomnia)?	Y N
2.	Is the request for ZolpiMist (zolpidem) oral spray or Edluar (zolpidem) sublingual tablets?	Y N
	[If no, then skip to question 6.]	
3.	Is the requested drug being prescribed for insomnia characterized by difficulties with sleep initiation?	Y N

4.	Is the patient unable to swallow tablets/capsules?	Y N
5.	Does the patient require use of MORE than 30 tablets per month of Edluar (zolpidem) sublingual tablets or 1 container of ZolpiMist (zolpidem) oral spray?	Y N
	[No further questions.]	
6.	Is the requested drug being prescribed for insomnia when middle-of-the-night awakening is followed by difficulty returning to sleep?	Y N
7.	Is the patient a biological female or a person that self-identifies as a female?	Y N
	[If yes, then go to question 9.]	
8.	Does the patient require use of MORE than 30 tablets per month of Intermezzo (zolpidem) sublingual tablets 1.75 mg or 3.5 mg?	Y N
	[No further questions.]	
9.	Is the request for the 1.75 mg strength for a dose not exceeding 1.75 mg per day?	Y N
10.	Does the patient require use of MORE than 30 tablets per month of Intermezzo (zolpidem) sublingual tablets 1.75 mg?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date