Prior Authorization Form

Intermezzo

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 Intermezzo.

Drug Name (select from list of drugs shown)

Intermezzo 1.75mg Tablets (zolpidem sublingual)	Intermezzo 3.5mg Tablets (zolpidem sublingual)	Zolpidem 1.75mg SL Tablets
Zolpidem 3.5mg SL Tablets		

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