SED/HYP.15
Form # 30110
R: 4.14

State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
SEDATIVE / HYPNOTICS

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| Patient Name: ______________________ DOB: __________
(NOT MEDICARE NUMBER)
Patient Address:____

Provider DEA: |__|__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:____________________________________ Phone:__________

Provider Address:__________________________________ Fax:__________

Pharmacy Name:______________Rx Address:______________Rx phone:__________

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Please use the Brand Name PA form for Brand Benzodiazepines requests and Ambien (step 7) requests.

BENZODIAZEPINES (members may get 10 per month of these Benzodiazepines without PA)

Drug Name (Step Order)	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Circle Refills
❑ Estazolam	______	______________	______	________	1 2 3 4 5
❑ Flurazepam	______	______________	______	________	1 2 3 4 5
❑ Temazepam	______	______________	______	________	1 2 3 4 5
❑ Triazolam	______	______________	______	________	1 2 3 4 5
❑ Doral	______	______________	______	________	1 2 3 4 5
❑ Other	______	______________	______	________	1 2 3 4 5

NON-BENZODIAZEPINES

Trazodone, Mirtazapine and Zolpidem are available without PA. PA will not be required for Zaleplon if a failed trial of Zolpidem is seen in member's drug profile. Although intermittent therapy is recommended, quantity limits will allow 30 tablets per 30 days supply without PA for all preferred medications. Non-preferred medications will require pa and dosing limits allowing 12 per 34 days supply will still apply.

Drug Name (Step Order)	Strength	Dosage Instructions	Quantity	Days Supply	Circle Refills
❑ Zolpidem ER (7)	______	______________	______	________	1 2 3 4 5
❑ Lunesta (8)	______	______________	______	________	1 2 3 4 5
❑ Rozerem (8)	______	______________	______	________	1 2 3 4 5
❑ Sonata (8)	______	______________	______	________	1 2 3 4 5
❑ Other______	______	______________	______	________	1 2 3 4 5

Medical Necessity Documentation

❑ Insomnia secondary to vital concurrent medication (e.g. Interferon) or Diagnosis. Describe:
____

❑ Full insomnia evaluation (HX, PE, Workup) must be attached

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: ____________________ **Date of Submission:** ____________________
*MUST MATCH PROVIDER LISTED ABOVE