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 #: |__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

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. Trazodone and Mirtazapine are available without prior authorization (PA). Non-preferred medications requiring PA are subject to PDL dosing limits and step order.

NON-BENZODIAZEPINES

Drug Name (generic name)	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Circle Refills
❑ Eszopiclone	_____	_____	_____	_____	1 2 3 4 5
❑ Lunesta (eszopiclone)	_____	_____	_____	_____	1 2 3 4 5
❑ Zolpidem ER	_____	_____	_____	_____	1 2 3 4 5
❑ Sonata (zaleplon)	_____	_____	_____	_____	1 2 3 4 5
❑ Other	_____	_____	_____	_____	1 2 3 4 5

INSOMNIA MEDICATIONS - OTHER

For insomnia secondary to SUD, daily ramelteon will not require PA when a MOUD medication is in member profile within past 45 days.

Drug Name (generic name)	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Circle Refills
❑ Belsomra (suvorexant)	_____	_____	_____	_____	1 2 3 4 5
❑ Dayvigo (lemborexant)	_____	_____	_____	_____	1 2 3 4 5
❑ Hetlioz (tasimelteon)	_____	_____	_____	_____	1 2 3 4 5
❑ Quviviq (daridorexant)	_____	_____	_____	_____	1 2 3 4 5
❑ Rozerem (ramelteon)	_____	_____	_____	_____	1 2 3 4 5
❑ Other	_____	_____	_____	_____	1 2 3 4 5

BENZODIAZEPINES (PA required for greater than 10 units per 30 days)

Drug Name 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
❑ Other	_____	_____	_____	_____	1 2 3 4 5

Medical Necessity Documentation

- ❑ Insomnia secondary to vital concurrent medication (e.g. Interferon) or diagnosis with full insomnia evaluation (HX, PE, Workup) attached.
- ❑ Describe: _____

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**