



Please note: All information below is required to process this request.
 Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



Rozerem® & Zolpimist® Prior Authorization Request Form
 DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

| Member Information <small>(required)</small> | | | Provider Information <small>(required)</small> | | |
|--|--------|------|--|--------|--------------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NP#: | | Specialty: |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |
| Medication Information <small>(required)</small> | | | | | |
| Medication Name: | | | Strength: | | Dosage Form: |
| <input type="checkbox"/> Check if requesting brand | | | Directions for Use: | | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | | | |
| Clinical Information <small>(required)</small> | | | | | |
| What is the patient's diagnosis for the medication being requested? _____ | | | | | |
| ICD-10 Code(s): _____ | | | | | |
| Select if the patient has tried and failed <u>at least 30 days</u> of the following medications: | | | | | |
| <input type="checkbox"/> Eszopiclone | | | | | |
| <input type="checkbox"/> Temazepam | | | | | |
| <input type="checkbox"/> Zaleplon | | | | | |
| <input type="checkbox"/> Zolpidem or zolpidem CR | | | | | |
| Quantity limit requests: | | | | | |
| What is the quantity requested per DAY? _____ | | | | | |
| Previous therapies failed and/or therapies currently used in combination with the requested medication (<i>List ALL medications tried or authorization process will be delayed</i>): _____ | | | | | |
| _____ | | | | | |
| Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If Yes , please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature). | | | | | |
| ** Please note: Chart documentation of the above is required to be submitted along with this fax | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| **Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.** | | | | | |
| *Previous therapies will be verified through pharmacy paid claims or submitted chart notes.* | | | | | |
| Prescriber Signature: _____ | | | Date: _____ | | |

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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