



Date _____

Client _____

PRIOR AUTH CRITERIA- HYPNOTICS

M.D. Last Name: _____ M.D. First Name: _____

Physician Phone: _____ Physician Fax: _____

Patient _____ ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please indicate which agent is being requested:

STEP B*

- Ambien CR
- Lunesta

STEP C**

- Branded Ambien
- Sonata

***Please note that if member is beginning therapy with a Hypnotic, the member's benefit will only cover generic zolpidem, unless the member has already tried and failed generic zolpidem**

****Please Note that Step C drugs will not be approved unless all Step B drugs have been tried and failed**

2. For Step B Coverage ONLY: Has the patient tried and failed a 30-day trial of generic zolpidem? Yes No

3. Please explain the reason for failure or non-trial, and attach notes from the patient's chart as documentation.

4. Is the patient pregnant? Yes No

5. Does the patient have a hypersensitivity to any of the components of Ambien, Ambien CR, Lunesta, or Sonata?
Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND. WI 53095

QUESTIONS PLEASE CALL:
877-526-9906