NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Sedative Hypnotics

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information
   Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ Other: _____ (Max length of therapy is 180 days)

Clinical Information

For Non-Preferred Drugs

1. Failed two preferred drug(s). List preferred drugs failed: _____
   1a. Allergic Reaction 1b. Drug-to-drug interaction. Please describe reaction: _____
2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
   _____
3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
   Please provide clinical information: _____
4. Age specific indications. Please give patient age and explain: _____
5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:
   _____
6. Unacceptable clinical risk associated with therapeutic change. Please explain: _____

Criteria for Quantity Limits: Exceeding Quantity of 15 per 30 days (check all that apply)

1. Does beneficiary have a diagnosis of chronic primary insomnia lasting one month or longer? ☐ Yes ☐ No
2. Has beneficiary received information on good sleep hygiene and had a documented trial (at least 3 weeks) of non-pharmacological therapies (ex. stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy)? ☐ Yes ☐ No
3. Does beneficiary have diagnosis of chronic secondary or co-morbid insomnia lasting one month or longer and has been evaluated for and is being actively treated for one of the below conditions? ☐ Yes ☐ No Please check appropriate condition:
   ☐a. underlying psychiatric illness associated with insomnia
   ☐b. underlying medical illness associated with insomnia (ex. chronic pain associated with cancer, inflammatory arthritis etc.)
   ☐c. sleep disorder such as restless legs syndrome, sleep-related breathing disorder, sleep related movement disorder, or circadian rhythm disorder
4. Is beneficiary being discontinued from a sedative hypnotic and tapering is required to prevent symptoms of withdrawal? ☐ Yes ☐ No
5. Is beneficiary being actively assessed for a diagnosis of chronic primary or secondary/co-morbid insomnia? ☐Yes ☐ No (Do not check "yes" if answer to #1 above is "yes")

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505