



NC DMA Pharmacy Request for Prior Approval Sedative Hypnotics



Recipient Information

DMA-0022 (V.01)

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

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9a. Drug Name: _____ 9b. Is this request for a Non-Preferred Drug? Yes No
10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): up to 30 60 Other: _____

Clinical Information

Request for Non-Preferred Drug:

1. Failed two preferred drug(s). If only one preferred drug is available, then failed one preferred drug.
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 exceeding quantity limit: (check all that apply)

7. Does patient have a diagnosis of chronic primary insomnia lasting one month or longer? Yes No
8. Has the patient received information on good sleep hygiene? Yes No
9. Does patient have a 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 following conditions? Yes No
If item 3 was checked "yes," then please check appropriate condition:
a. an underlying psychiatric illness associated with insomnia b. an underlying medical illness associated with insomnia (e.g. chronic pain associated with cancer, inflammatory arthritis, etc.) c. a sleep disorder such as restless legs syndrome, sleep-related breathing disorder, sleep-related movement disorder or circadian rhythm disorder
10. Is patient being discontinued from a sedative hypnotic and tapering is required to prevent symptoms of withdrawal? Yes No
11. Is patient being actively assessed for a diagnosis of chronic primary or secondary/co-morbid insomnia?
 Yes No (Do not check "yes" if answer to #1 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 CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505