



# Mountain-Pacific Quality Health Foundation

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*"The best quality health care is provided to every patient we serve, every time."*

## Prior Authorization Request Form for Daily Use of Lunesta® (eszopiclone) or Rozerem® (ramelteon)

1. Patient's Name: \_\_\_\_\_ 2. Date: \_\_\_\_\_
3. I. D. Number: \_\_\_\_\_ 4. D.O.B: \_\_\_\_\_
5. Physician's Name: \_\_\_\_\_
6. Physician's Phone # \_\_\_\_\_ 7. Physician's Fax Number: \_\_\_\_\_
8. Dose Request: \_\_\_\_\_ (mg) 9. Daily Directions: \_\_\_\_\_ (Ex: 1 QD)

Please answer the following questions by checking yes or no:

EVIDENCE	YES	NO	COMMENTS BY PROVIDER
10. Is the patient 18 years or older?			
11. Is the patient currently taking a stimulant medication (ex: methylphenidate, Concerta, Adderall XR, Focalin, Strattera, Xyrem, Provigil) to promote wakefulness during the day?			
12. Is the diagnosis documented as "chronic insomnia"?			
13. Has the patient had symptoms of difficulty falling asleep, frequent nocturnal awakenings or early awakenings for at least three nights per week for three consecutive months?			
14. Has the patient failed a reasonable drug regimen to at least <b>two</b> multi-source medications, prescribed for sleep, from the following list? <b>Tricyclic Antidepressants</b> <b>Mirtazapine</b> <b>Benzodiazepines</b> <b>Trazodone</b> <b>Antihistamines</b>			PA Unit will verify patient's prescription history
15. Has the patient failed a reasonable regimen of two multi-source medications (a minimum of 2 months) in addition to at least a 1 month trial of an approved quantity (15 tablets) of the requested drug?			<b>Required</b>
16. If YES to 14, please list the two most recent agents prescribed:	1. _____	2. _____	

17. Signature of Physician: \_\_\_\_\_

### Important Notice

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