HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
CHRONIC INSOMNIA
Belsomra®, Rozerem®, Silenor®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Belsomra® (suvorexant), ☐ Rozerem® (ramelteon), ☐ Silenor® (doxepin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Has the member been diagnosed with chronic insomnia?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. Does the member have functional distress or impairment caused by poor sleep?	☐	☐	**Please provide documentation**
4. Has the member experienced poor sleep for at least 3 nights per week for at least 3 months?	☐	☐	**Please provide documentation**
5. Is the sleep disorder related to medication or other mental disorders?	☐	☐	**Please provide documentation**
6. Have the following causes been ruled out: obstructive sleep apnea, chronic obstructive pulmonary disease, depression and anxiety?	☐	☐	**Please provide documentation**
7. Has the member had cognitive behavioral therapy for insomnia for ≥3 months?	☐	☐	**Please provide documentation**
8. Has the member had at least a 3 month trial and failure of, or contraindication to, over-the-counter sleep aids (e.g. melatonin, diphenhydramine, or doxylamine)?	☐	☐	**Please provide documentation**
9. Has the member had at least a 3 month trial and failure of, or contraindication to, ≥1 generic antidepressant (e.g. amitriptyline, trazodone, etc.)?	☐	☐	**Please provide documentation**

10. Has the member had at least a 3 month trial and failure of, or contraindication to, ≥1 generic non-benzodiazepine hypnotic medication (e.g. zolpidem, zaleplon, eszopiclone)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member meet at least two of the following: • Time to onset of sleep has improved, total time asleep has improved, number of night awakenings reducing quality of sleep has improved	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

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Policy PHARM- 038
Origination Date: 11/26/2018
Reviewed/Revised Date: 01/22/2020
Next Review Date: 01/23/2021
Current Effective Date: 01/23/2020