MICHIGAN
Department Of Community Health Pharmacy Program
Prior Authorization Request for
Sedative / Hypnotic Therapy Exceeding 102 Days

All information on this form must be addressed. Incomplete forms will be returned once for missing information. Mark as 'N/A' if no information is available or does not apply. Issues that remain blank after being returned once, will receive a denial and will not qualify for MDCH physician review until completed.

Prescribing Physician:

Name: _____
First Last

Phone #: ___-___-____

Fax #: ___-___-____

NPI: ____________
NPI accepted as of April 17, 2007

Beneficiary: ☐ Male ☐ Female

Name: _____
First Last

Medicaid #: ____________

Date of Birth: __-__-____

Specialty: _____

Person completing form: _____ **Rqstd start date:** _____
Name Title Date

Pharmacy: _____ **Phone #:** ___-___-____

Drug Name	Strength	Dose	Duration of Rx

Diagnosis/medical necessity for long-term sedative/hypnotic: _____

Please note all other providers that are involved in therapy for this diagnosis. Please note each provider's specialty and recommendation(s) as relates to the long-term sedative/hypnotic therapy.

_____

_____

Please note all other current diagnoses, treatments (medication/non-medication), and status of treatment regimen(s) (ex. stable, titrating) that impact on the recipient's need for the long-term sedative/hypnotic therapy. Please note specific reason(s) , i.e., symptoms, signs, symptoms from other diagnoses or medications etc., why there is an ongoing need for a sleep aid, and why adjusting other medications or treating the other diagnoses are unsuitable for this recipient.

_____

_____

Have there been any attempts to wean the recipient off this therapy or reduce the dosage? YES NO
If "YES", please describe the attempt and reason for failure. _____

Please specify issues of sleep hygiene that have been addressed with the recipient.

_____

_____

Please note any laboratory test(s) or procedure(s), date(s), & findings(s) (ex. sleep study if applicable):

_____

If the recipient has coverage through Medicare Part D, and the requested medication above is a benzodiazepine (Medicare Part D excluded drug class), have non-benzodiazepine options with Medicare Part D for this diagnosis/therapy been considered/utilized to the fullest? YES NO
If "YES", please note the medication(s) tried and reason for failure. _____

If "NO", why not? _____

Additional comments: _____

Submit requests to: **First Health Services, MAP Department, 4300 Cox Road, Glen Allen, VA 23060**
Fax: 888-603-7696 Phone: 877-864-9014
This form is available at www.michigan.fhsc.com -> Providers -> Forms

Revised 10-12-07