Prescriber Criteria Form

HRM Hypnotics 2025 PA Fax 1421-B v2 010125.docx
High Risk Medications (HRM) Criteria – Hypnotics Non-Benzodiazepines
Eszopiclone, Zaleplon, Zolpidem Extended-Release, Zolpidem Immediate-Release, Zolpidem Spray, Zolpidem Sublingual
This HRM List applies to formulary drugs only.
Prior Authorization applies only to patients 70 years of age or older.
Prior Authorization applies to greater than cumulative 90 days of therapy per year,
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of High Risk Medications (HRM) Criteria – Hypnotics Non-Benzodiazepines.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of insomnia? [If no, then no further questions.]	Yes ◯	No ◯
2	The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Has the patient tried the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg)? [If yes, then skip to question 4.]	Yes ◯	No ◯
3	Does the patient have a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg)? [If yes, then skip to question 6.] [If no, then no further questions.]	Yes ◯	No ◯

4	Has the patient experienced an inadequate treatment response to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg)? [If yes, then skip to question 6.]	Yes ◯	No ◯
5	Has the patient experienced an intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg)? [If no, then no further questions.]	Yes ◯	No ◯
6	Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient? [If no, then no further questions.]	Yes ◯	No ◯
7	Is the patient using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug? [If no, then no further questions.]	Yes ◯	No ◯
8	Has the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient? [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____