BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND-LIFESPAN PREMIER

Insomnia Agents

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 **1-888-836-0730**.

Please contact CVS|Caremark at **1-877-203-0814** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Insomnia Agents.

Drug Name (select from list of drugs shown)

Edluar sublingual tablets (zolpidem) Lunesta (eszopiclone) Zolpimist oral spray (zolpidem)

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each applicable question.

1. Is the request for Lunesta 3mg? Y N

   [If the answer to this question is no, skip to question 3.]

2. Is the patient 64 years of age or younger? Y N

3. Has the patient tried, failed or is the patient intolerant to generic zolpidem or zolpidem ER? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature and Date