

Sedative Hypnotics

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____

Street

Suite #

City

State

Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

Wellmark Step Therapy requires patients to try zolpidem (Ambien IR) or zaleplon (Sonata) prior to moving to any Step 2 sedative hypnotic.

1. Please provide the diagnosis this therapy has been prescribed for: _____

2. Select all previous sedative hypnotic(s) the patient has tried and failed (check all that apply):

Zaleplon Zolpidem

3. Reason(s) for discontinuing Zaleplon or Zolpidem, or why the patient is unable to take these product(s):

4. Requested Drug: Ambien CR Edluar Lunesta Rozerem Zolpimist

Strength: _____

Quantity Requested/30 days: _____

Printed Name

Signature

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