Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Sedative Hypnotics

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ Other:_____ (Max therapy length is 180 days)

Clinical Information

For Non-Preferred Drugs

1. Failed two preferred drug(s). List preferred drugs failed: _____
   a. Was the failure due to an allergic reaction? ☐ **Yes** ☐ **No**
   b. Was the failure due to a drug-to-drug interaction? ☐ **Yes** ☐ **No**
   Please describe reaction: _____
2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
   _____
3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
4. Age specific indications. Please give patient age and explain: _____
5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
6. Unacceptable clinical risk associated with therapeutic change. Please explain: _____

Criteria for Quantity Limits: Exceeding Quantity of 15 per 30 days (check all that apply)

7. Does member have a diagnosis of chronic primary insomnia lasting one month or longer? ☐ **Yes** ☐ **No**
8. Has member received information on good sleep hygiene and had a documented trial (at least 3 weeks) of non-pharmacological therapies (ex. stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy)? ☐ **Yes** ☐ **No**
9. Does member have diagnosis of chronic secondary or co-morbid insomnia lasting one month or longer and has been evaluated for and is being actively treated for one of the below conditions? ☐ **Yes** ☐ **No**
   Please check appropriate condition:
   ☐ a. underlying psychiatric illness associated with insomnia
   ☐ b. underlying medical illness associated with insomnia (ex. chronic pain associated with cancer, inflammatory arthritis etc.)
   ☐ c. sleep disorder such as restless legs syndrome, sleep-related breathing disorder, sleep related movement disorder, or circadian rhythm disorder
10. Is member being discontinued from a sedative hypnotic and tapering is required to prevent symptoms of withdrawal? ☐ **Yes** ☐ **No**
11. Is the member being actively assessed for a diagnosis of chronic primary or secondary/co-morbid insomnia? ☐**Yes** ☐ **No** (Do not check "yes" if answer to #7 above is "yes")

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277