SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (select one below)

❑ **Belsomra®** (suvorexant)	❑ **Dayvigo®** (lemborexant)	❑ **quazepam** (Doral®)
❑ **Quviviq™**(daridorexant)	❑ **ramelteon** (Rozerem®)	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **For quazepam (Doral®) and ramelteon (Rozerem®) requests the following criteria must be met:**

- ❑ Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following medications:
  - ❑ eszopiclone
  - ❑ temazepam
  - ❑ zaleplon
  - ❑ zolpidem or zolpidem CR

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❑ **For Belsomra®, Dayvigo® and Quviviq™ requests the following criteria must be met:**

- ❑ Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following medications:
  - ❑ eszopiclone
  - ❑ temazepam
  - ❑ zaleplon
  - ❑ zolpidem or zolpidem CR
- ❑ Member has tried and failed **at least 30 days** of therapy with ramelteon (Rozerem®) 8 mg tablets **(*requires prior authorization)**

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: ~~1/21/2011,~~ 7/16/2020
UPDATED/REVISED/REFORMATTED: ~~2/28/2015; 12/19/2016; 8/14/2017; 6/18/2019; 1/22/2020, 11/12/2020; 6/21/2022; 8/7/2022; 12/20/2022; 10/20/2023;~~ ~~12/11/2023, 2/20/2025;~~ **12/30/2025**