ZOLPIDEM

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM
BlueCross® BlueShield® of South Carolina

Patient Information	
Name:	**Insurance ID #:**
Address:	**Birthdate:**

Provider Information	
Physician's Name:	**Physician DEA #:**
Phone:	**Fax:**
Office Address:	
Diagnosis:	**ICD-9 Code:**

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Does the patient require more than 30 tablets/capsules per 60 days of Ambien, Ambien CR, Edluar, Lunesta, Rozerem or Sonata? Y N
   [Note: No authorization is required for up to 30 tablets/capsules or less every 60 days of Ambien, Ambien CR, Edluar, Lunesta, Rozerem or Sonata.}
2. Does the patient have the diagnosis of chronic insomnia? Y N
3. Have other causes of sleep disturbance been addressed? Y N
4. Has the patient received six months of sedative/hypnotic therapy? Y N
   [If the answer to this question is no, no further questions are required.]
5. Has the continued use of sedative/hypnotic therapy been evaluated and considered medically necessary? Y N

Comments: ______________________________

Information on this form is accurate as of the date below.

Prescriber's Signature:	**Date:**

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.