

ZOLPIMIST (zolpidem) STEP THERAPY

PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. Does the patient have a documented contraindication to or a potential drug interaction with generic zolpidem or zaleplon? Y N
[If the answer to this question is yes, no further questions are required.]
2. Is the patient intolerant to or had a confirmed adverse event with generic zolpidem or zaleplon? Y N
[If the answer to this question is yes, no further questions are required.]
3. Has the patient demonstrated an inadequate treatment response after at least a 30 day trial of generic zolpidem or zaleplon? Y N

Comments:

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

Prescriber (or Authorized) Signature and Date: