# Bravo Health

Coverage Review / Prior Authorization Request Form

**Hypnotics (Ambien CR®, Lunesta®, Sonata®, Rozerem® )**

| Patient Information | Prescriber Information |
|---|---|
| Member Name: | Prescriber Name: |
| Bravo ID # | Prescriber Specialty: |
| DOB: | Prescriber Address: |
| Address: | |
| | Office Phone#: |
| Home Phone: | Office Fax #: |
| | Contact Person: |

**Diagnosis and Medication Requested**

Medication Requested (dosage, frequency): Qty:

Prescribing Diagnosis: ICD9 Code Date Therapy Initiated:

**Clinical Criteria**

**Please answer the following questions:**

1. Has the patient has experienced an inadequate response or intolerance to the use of the generics: Zolpidem (Ambien®) and Zaleplon (Sonata®)**?

   ☐ Yes
   ☐ No*

***Request will be denied if above criteria is not met.**

****Please provide clinical notes supporting intolerance or failed therapy with Zolpidem (Ambien®) and Zaleplon (Sonata®).**

Additional Comments/Explanation:

**Request for Expedited Review**

☐ **REQUEST FOR EXPEDITED REVIEW [24 HOURS]**
**BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION**

**Prescriber's Signature:** _____ **Date:** _____

**Fax back to: 866-464-0709** **For info call: 877-813-5595**

**For additional Prior Authorization forms, go to http://www.bravohealth.com/providers.aspx**