Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization for use of Dual Orexin Receptor Antagonists (Belsomra®, Dayvigo®, Quviviq®)

Member Information	Prescriber Information
Name:	Name:
DOB:	Specialty:
Medicaid ID #:	Phone:
Date:	Fax:
Drug and Dose Requested:	Office Contact for Request:

I. Diagnosis History

1. Is member 18 years or older? ☐ YES ☐ NO If NO, approval will not be granted because this class of medications is not indicated for members under the age of 18.

2. Member has a diagnosis of insomnia: ☐ YES ☐ NO

3. Does the member have a current diagnosis or history of narcolepsy? ☐ YES ☐ NO If Yes, approval will not be granted as Narcolepsy is a contraindication of this class of medications.

4. Provider is aware of the increased risk of suicidal ideation with Orexin Receptor Antagonists? ☐ YES ☐ NO

5. Provider is aware of interaction of Orexin Receptor Antagonists with other CNS depressants (i.e. opioids, ethanol, etc.) and has discussed this with the member: ☐ YES ☐ NO

6. Has prescriber considered or recommended clinic based or electronically delivered Cognitive Behavioral Therapy and Mindfulness for insomnia? ☐ YES ☐ NO If no, please provide additional information as to why.

   _____

   _____

II. Medication History:

1. Member must have documented inadequate response (at appropriate doses), or contraindication within the last 24 months, to **TWO (2)** of the following, for a minimum trial of 14 days each:

   ☐ Zolpidem – Dates of Use _____

   ☐ Eszopiclone – Dates of Use _____

   ☐ Zaleplon – Dates of Use _____

2. **AND** member must have a documented inadequate response (at appropriate doses), or contraindication within the last 24 months, to low dose doxepin, for a minimum trial of 14 days:

   Dosage: _____ Dates of Use: _____

3. For Dayvigo® or Quviviq® requests, member has had an inadequate response, or contraindication to Belsomra®: ☐ YES ☐ NO Dates of Use: _____

III. Limitations:

- Maximum dose allowed is one tablet daily.
- Initial approval will be granted for 3 months
- Renewal authorization will be granted in increments of 6 months
- Provider must attest that member has benefitted from this medication to renew coverage.
- Duplication with other sedative hypnotics will not be approved.

Please complete this form in its entirety and fax to:

Drug Prior Authorization Unit at 1-800-294-1350

03/2023