**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Dual Orexin Receptor Antagonists (Belsomra, Dayvigo, and Quviviq)**
**Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Dual Orexin Receptor Antagonists (Belsomra, Dayvigo, and Quviviq).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

**KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

**1 – Patient Information**

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

**2 – Prescriber Information**

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

**3 – Pharmacy Information**

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

**Clinical Criteria:**

1. Prescriber is a Psychiatrist, Pulmonologist (Sleep Specialist) or Neurologist,
   □ No □ Yes

2. **AND** patient has a diagnosis of insomnia characterized by difficulty with sleep onset and/or staying asleep,
   □ No □ Yes

3. **AND** if the patient is ≥65 years of age: documented trial (≥2 weeks) with treatment failure, contraindication, or intolerance to OTC melatonin or ramelteon and trazodone,
   □ No □ Yes

4. **AND** if the patient is 18 years to 64 years of age: documented trial (≥2 weeks) with treatment failure, inadequate response, or contraindication to using at least 3 agents for insomnia:
   a. OTC melatonin
   b. Trazodone
   c. Ramelteon
   d. Zaleplon
   e. Doxepin (max 6 mg/day)
   f. Zolpidem

   □ No □ Yes

5. **AND additional criteria for Belsomra and Quviviq:** trial of preferred dual orexin receptor antagonist, Dayvigo, for a minimum of 2 weeks
   □ No □ Yes

**For continuation of therapy, please respond to additional questions below:**

1. Patient meets all the initial criteria for coverage,
   □ No □ Yes

2. **AND** documentation of positive clinical response
   □ No □ Yes

**6 – Prescriber Sign-Off**

**Additional Information –**

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Prescriber Signature:** | **Date:** |
|---|---|
| | |