



**Medicare Part D Coverage Determination Request Form for Temazepam**

**Instructions:** Please complete ALL FIELDS and fax this form to WellCare's Pharmacy Department at **1-866-388-1767**. Formulary and utilization management criteria may be reviewed at [www.wellcare.com/medicare](http://www.wellcare.com/medicare).

**Who is making this request?**    Provider

*Appointed Representatives:* Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

**REQUEST FOR EXPEDITED REVIEW (24 HOURS)**

By checking the expedited box, the requestor certifies 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.

**\*REQUIRED FIELDS – ONE medication per form**

*Member Name:		*Date of Request:	
*WellCare ID #:	*Date of Birth:	*Physician FULL Name/Specialty:	
*Member's Telephone Number:		*Physician Signature:	
*Diagnosis of Requested Medication:		*Contact Name at MD Office:	*Physician NPI:
*Medication, Strength, and Route of Administration:		*Physician Phone #:	*Physician Fax #:
		Pharmacy Name:	Pharmacy Phone #:
*Frequency:	*Quantity:	*Duration of Therapy:	*Drug Allergies:
<p><b><i>Temazepam requires prior authorization for requests greater than a cumulative 90 days of therapy per year. PLEASE COMPLETE THIS SECTION IF THE PATIENT IS 65 OR OLDER:</i></b></p> <p>1) Has the patient tried a non-high risk medication (HRM) alternative formulary drug (Silenor 3mg or 6mg, Rozerem, or trazodone)?  <input type="checkbox"/> YES    <input type="checkbox"/> NO            If yes, please indicate which formulary drug tried: _____</p> <p>2) Does the patient have a contraindication, intolerance, or an inadequate response to a non-HRM alternative formulary drug (Silenor 3mg or 6mg, Rozerem, trazodone)?  <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>3) Does the benefit of therapy with this prescribed medication outweigh the potential risk in the patient 65 years of age or older?  <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>4) Is the request for more than once a day dosing?    <input type="checkbox"/> YES    <input type="checkbox"/> NO            If yes, we require a statement that the drug is medically necessary to treat the enrollee's condition because the restricted dosage might be ineffective or affect patient compliance.</p> <p><b>Supporting statement:</b></p> <p>_____</p> <p>_____</p> <p>_____</p>			