Physician Request Form for Benzodiazepines
Fax to Pharmacy Services at 1-855-829-2872, or call 1-855-251-0966
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas Delaware

Patient name:_____ Patient ID: _____
Patient address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ Weight:_____
Prescriber name: _____ NPI: _____
Prescriber address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____
Contact name: _____
Requested Medication name, strength, quantity, directions, and duration: _____

_____

Diagnosis:_____

For Initial Requests

- Is the patient using the requested medication for palliative care, hospice, or end-of-life care? ☐Yes ☐No
- Please provide the patient's previous treatment history and response:

  _____
- Is the patient currently taking an opioid? ☐Yes* ☐No
  *If yes, has the patient been counseled on the risks of concurrent benzodiazepine and opioid use? ☐Yes ☐No
- Will the patient be concurrently taking another benzodiazepine, muscle relaxant, or sedative hypnotic drug (e.g. zolpidem, zaleplon)? ☐Yes* ☐No
  *If yes, has the patient been counseled on the risks of concurrent use of these medications? ☐Yes ☐No
- The prescriber attests to checking the Delaware PDMP: ☐Yes ☐No
- For a diagnosis of insomnia, if the request is for a duration greater than 14 days, has the patient tried all of the following:
  - A non-benzodiazepine drug therapy for insomnia for at least 4 weeks [e.g. zolpidem, zaleplon, a sedating antidepressant (e.g. trazodone, mirtazapine, amitriptyline, doxepin), a sedating antipsychotic (e.g. quetiapine, olanzapine), or a sedating anticonvulsant (e.g. gabapentin, tiagabine): ☐Yes* ☐No
    *If yes, please specify which medication(s): _____
  - Non-pharmacologic therapy (e.g. stimulus control, relaxation training, cognitive behavioral therapy): ☐Yes ☐No
  - Sleep hygiene measures: ☐Yes ☐No
- For a diagnosis of anxiety or panic disorder, if the request is for a duration greater than 14 days, has the patient tried at least two of the following:
  - Psychotherapy (e.g. cognitive behavioral therapy, applied relaxation) ☐Yes ☐No
  - Antidepressant medications (e.g. SSRIs, SNRIs, tricyclic antidepressants) ☐Yes* ☐No
    *If yes, please specify which medication(s): _____
  - Other serotonergic agents (buspirone, trazodone) ☐Yes* ☐No
    *If yes, please specify which medication(s): _____
  - Other alternative agents: hydroxyzine, bupropion, olanzapine, risperidone, quetiapine, or pregabalin ☐Yes* ☐No
    *If yes, please specify which medication(s): _____
- For a diagnosis of restless leg syndrome, if the request is for a duration greater than 14 days, has the patient tried all of the following:
  - Prescriber attests that iron deficiency has been ruled out or if patient is iron deficient, they have been adherent to iron + vitamin C regimen for at least 3 months ☐Yes ☐No
  - Patient has implemented good sleep hygiene practices ☐Yes ☐No
  - Patient has tried TWO of the following pharmacologic treatments: pramipexole, ropinirole, gabapentin, Horizant (gabapentin enacarbil), Neupro (rotigotine), cabergoline, or pregabalin: ☐Yes* ☐No
    *If yes, please specify which medication(s): _____

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- For a diagnosis of chronic muscle spasms or spasticity, if the request is for a duration greater than 14 days, has the patient tried at least two of the following: tizanidine, baclofen, riluzole, dantrolene, cyclobenzaprine, carisoprodol, methocarbamol, orphenadrine, or chlorzoxazone. ☐Yes* ☐No
  *If yes, please specify which medication(s): _____
- Rationale and/or additional information, which may be relevant to the review of this prior authorization request:
  _____
  _____
  _____

For Renewal Requests

- Is the patient currently taking an opioid? ☐Yes* ☐No
  *If yes, has the patient been counseled on the risks of concurrent benzodiazepine and opioid use? ☐Yes ☐No
- Will the patient be concurrently taking another benzodiazepine, muscle relaxant, or sedative hypnotic drug (e.g. zolpidem, zaleplon)? ☐Yes* ☐No
  *If yes, has the patient been counseled on the risks of concurrent use of these medications? ☐Yes ☐No
- The prescriber attests to checking the Delaware PDMP: ☐Yes ☐No
- Is a benzodiazepine tapering/discontinuation plan in place? ☐Yes* ☐No
  *If yes, please provide plan: _____
  _____
  _____
- Is a benzodiazepine the only adequate treatment for the patient's disease state? ☐Yes* ☐No
  *If yes, please provide the rationale below:
  _____
  _____
  _____

Prescriber Signature: _____ **Print Name:** _____ **Date**: _____

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