Prescriber Criteria Form Hypnotics Temazepam 2026 PA Fax 3501-B v1 010126.docx Restoril (temazepam) Prior Authorization applies only to patients 65 years of age or older. Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Restoril (temazepam).

Drug Name: Restoril (temazepam)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the short-term treatment of insomnia? [If no, then no further questions.]	Yes	No
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following: A) doxepin (3mg or 6mg), B) ramelteon? [If no, then no further questions.]	Yes	No
3	Does the benefit of therapy with this prescribed medication outweigh the potential risks for the patient? [Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.] [If no, then no further questions.]	Yes	No
4	Is the patient using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug? [If no, then no further questions.]	Yes	No
5	Has the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient?	Yes	No

	[Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]		

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____