

******Chronic use of benzodiazepines, opiates, muscle relaxants, sleep medications, including sedating antihistamines used specifically for sleep, narcotics and narcotic-like medication, or other sedating medication (other than antihistamines).**

	Disqualifying meds	Due to your use of _____, please submit an evaluation performed by your treating provider documenting the complete history of the condition under treatment with this medication, frequency and severity of symptoms, your current functional status, treatment plan with all medications/side effects, and prognosis. Provide reports from any pertinent diagnostic testing and any hospitalizations associated with this condition. Please submit pharmacy records documenting dispensing history for the 12-month period from _____ to _____. All information requested should be within the past twelve months unless otherwise noted.
--	--------------------	--