carolina complete health

Pharmacy Prior Approval for

Hetlioz and Hetlioz LQ

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender:_____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (In days): Initial Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days

Re-authorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

Standard Questions for Treatment:

1. Does the member have a documented diagnosis of Non-24 sleep-wake disorder? ☐ **Yes** ☐ **No**
2. Is the member at least 18 years old or older? ☐ **Yes** ☐ **No**
3. The diagnosis of Non-24 sleep-wake disorder is confirmed by meeting ONE of the following conditions:
   - ☐ Assessment of at least one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset [as measured in blood or saliva], assessment of core body temperature
   - ☐ Assessment of at least one physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for >/= 1 week plus evaluation of sleep logs recorded for >/= 1 month
4. Is the beneficiary blind? ☐ Yes ☐ No

OR

5. Does the member have documented diagnosis of Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) ☐ **Yes** ☐ **No**
6. Is the member at least 16 years old or older? ☐ **Yes** ☐ **No**

Initial Authorization for Treatment:

7. Has the beneficiary had an insufficient response or intolerance to at least two (2) other medications for sleep? ☐ **Yes** ☐ **No**
8. Is this medication being prescribed by, or is the physician consulting with, a physician who specialized in the treatment of sleep disorders? ☐ **Yes** ☐ **No**

Re-authorization for Treatment:

9. Has the beneficiary used Hetlioz or Hetlioz LQ continuously without gaps in treatment for the initial approval period of three (3) months? ☐ **Yes** ☐ **No**
10. As the provider, have you included an objective evaluation of the beneficiary's sleep quality, including documentation of an improvement in overall sleep quality while taking Hetlioz or Hetlioz LQ? ☐ **Yes** ☐ **No**

**Documentation of the beneficiary's overall sleep quality improvement must accompany this reauthorization for Hetlioz or Hetlioz LQ. **

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (866) 399-0929 Pharmacy PA Call Center: (833) 585-4309