

Pharmacy Prior Approval for Hetlioz/ Hetlioz LQ/ tasimelteon

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

HETLIOZ and tasimelteon (complete questions 1-5 for Helioz and tasimelteon)

1. Is the beneficiary 18 years old or older? Yes No
2. Does the beneficiary have a documented diagnosis of Non-24 sleep-wake disorder? 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 \geq 1 week plus evaluation of sleep logs recorded for \geq 1 month
4. Is the beneficiary 16 years old or older? Yes No
5. Does the beneficiary have a diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)? Yes No

HETLIOZ LQ (complete questions 6-7 for Hetlioz LQ)

6. Is the beneficiary between 3 years and 15 years of age? Yes No
7. Does the beneficiary have a diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)? Yes No

Hetlioz and Hetlioz LQ: (complete questions 8-9)

8. Has the beneficiary had an insufficient response or intolerance to at least two (2) other medications for sleep? (can be over-the-counter or prescription) Yes No
9. 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 Hetlioz and Hetlioz LQ: (complete questions 10-11)

10. Has the beneficiary used Hetlioz/Hetlioz LQ continuously without gaps in treatment for the initial approval period of three (3) months? Yes No
11. 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/Hetlioz LQ? Yes No

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