PRIOR AUTHORIZATION REQUEST

Hetlioz

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Non-24-hour sleep-wake disorder (If checked, go to 2) [] Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) (if checked, go to 6) [] Other (If checked, no further questions)		
2	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
3	Is the patient completely blind with NO light perception?	Yes	No

If you have any questions, call: 1-888-258-8250

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	[If no, no further questions.]		
4	Does the patient have a history of AT LEAST 3 months of difficulty initiating sleep, difficulty awakening in the morning, or excessive daytime sleepiness? [If no, no further questions.]	Yes	No
5	Does the patient have any other concomitant sleep disorder (such as sleep apnea or insomnia)? [No further questions.]	Yes	No
6	Does the patient have a confirmed diagnosis of SMS supported by chromosome analysis showing deletion of 17p11.2 or mutation of the RA11 gene? [If no, no further questions.]	Yes	No
7	Has the patient experienced an inadequate response or inability to tolerate a trial of melatonin? [If no, no further questions.]	Yes	No
8	What is the requested product? [] Hetlioz (tasimelteon) capsules (If checked, go to 9) [] Hetlioz LQ (tasimelteon) oral suspension (if checked, go to 10)		
9	Is the patient greater than or equal to 16 years of age? [No further questions.]	Yes	No
10	Is the patient between the ages of 3 and 15 years of age?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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