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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request for an INITIAL or a CONTINUATION of therapy?

[] Initial (If checked, go to 6)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 6.]

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

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 6.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of adequate results with tasimelteon capsules therapy include entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep.] [No further questions.]	Yes	No
6	What is the diagnosis or indication? [] Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) (If checked, go to 7) [] Non-24-hour sleep-wake disorder (If checked, go to 17) [] Other (If checked, no further questions)		
7	Has documentation been submitted to confirm the diagnosis of Smith-Magenis Syndrome (SMS) supported by chromosome analysis showing deletion of 17p11.2 or mutation of the *RA11* gene? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Has documentation been submitted to confirm the patient has had a treatment failure with behavioral interventions? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of behavioral interventions include relaxation training, stimulus control therapy, sleep restriction therapy, sleep hygiene, paradoxical intention therapy, cognitive restructuring, and other approaches.] [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has had a treatment failure with acebutolol AND melatonin for AT LEAST 3 months, unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	What is the requested product? [] Hetlioz (tasimelteon) capsules (If checked, go to 11) [] Hetlioz LQ (tasimelteon) oral suspension (If checked, go to 14)		

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11	Is the patient greater than or equal to 16 years of age? [If no, no further questions.]	Yes	No
12	Is the requested medication being prescribed by, or in consultation with a physician who specializes in the treatment of sleep disorders? [If no, no further questions.]	Yes	No
13	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 20 mg once daily 1 hour prior to bedtime; take at the same time each night.] [No further questions.]	Yes	No
14	Is the pediatric patient between the ages of 3 to 15 years of age? [If no, no further questions.]	Yes	No
15	Is the requested medication being prescribed by, or in consultation with a physician who specializes in the treatment of sleep disorders? [If no, no further questions.]	Yes	No
16	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: less than or equal to 28 kg: 0.7 mg/kg/dose once daily 1 hour before bedtime; greater than 28 kg: 20 mg once daily 1 hour before bedtime.] [No further questions.]	Yes	No
17	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
18	Is the patient completely blind with NO light perception? [If no, no further questions.]	Yes	No
19	Has documentation been submitted to confirm the diagnosis of non-24-hour sleep wake disorder? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of physiological circadian phase markers include measurement of urinary melatonin levels, dim light melatonin onset (as measured in blood or saliva), and assessment of core body temperature OR confirmed by actigraphy.] [If no, no further questions.]	Yes	No
20	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
21	Does the patient have any other concomitant sleep disorder (such as sleep apnea or insomnia)? [If yes, no further questions.]	Yes	No

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22	Has documentation been submitted to confirm the patient has had a treatment failure with behavioral interventions? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of behavioral interventions include relaxation training, stimulus control therapy, sleep restriction therapy, sleep hygiene, paradoxical intention therapy, cognitive restructuring, and other approaches.] [If no, no further questions.]	Yes	No
23	Has documentation been submitted to confirm the patient has had a treatment failure with melatonin for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Is the requested medication being prescribed by, or in consultation with a physician who specializes in the treatment of sleep disorders? [If no, no further questions.]	Yes	No
25	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 20 mg once daily 1 hour prior to bedtime; take at the same time each night.]	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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If you have any questions, call: 1-888-258-8250