Iowa Department of Human Services

Request for Prior Authorization
TASIMELTEON (HETLIOZ®)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for tasimelteon (Hetlioz®). Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered under the following conditions: 1) Patient has a diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as confirmed by a sleep specialist; and 2) Patient is 18 years of age or older; and 3) Documentation the patient is totally blind with no perception of light is provided; and 4) Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and 5) Patient has a documented trial and therapy failure with ramelteon (Rozerem®). If criteria for coverage are met, initial requests will be approved for 3 months. Requests for continuation of therapy will be considered when the patient has received 3 months of continuous therapy and patient has achieved adequate results with tasimelteon (Hetlioz®), such as entrainment, significant increase in nighttime sleep, and/or significant decreases in daytime sleep.

Non-Preferred

☐ Hetlioz®

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Has diagnosis been confirmed by a sleep specialist? ☐ Yes (attach documentation) ☐ No

Is patient totally blind with no perception of light? ☐ Yes (attach documentation) ☐ No

Treatment failure with a preferred sedative/hypnotic-non-benzodiazepine agent:

Drug name & dose: _____ Trial dates: _____

Reason for failure: _____

Treatment failure with ramelteon (Rozerem®):

Trial dose: _____ Trial dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies: _____

Request for Prior Authorization
TASIMELTEON (HETLIOZ®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Requests for continuation therapy:

Has patient received 3 months of continuous tasimelteon (Hetlioz®) therapy? ☐ Yes ☐ No

Has patient achieved adequate results with tasimelteon (Hetlioz®) therapy? ☐ Yes (describe below) ☐ No

Patient improvements with tasimelteon (Hetlioz®) therapy (include description):

☐ Entrainment: _____

☐ Significant increase in nighttime sleep: _____

☐ Significant decrease in daytime sleep: _____

☐ Other: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*