



Request for Prior Authorization
TASIMELTEON (HETLIOZ®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, 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) Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and 4) 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

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:

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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.

| | |
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| 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.*