SANDHILLS CENTER

Pharmacy Request for Prior Approval – Hetlioz and Hetlioz LQ

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: Initial Request: __up to 30 days __60 days __90 days
Reauthorization Request: __up to 30 days __60 days __90 days __120 days __180 days

Clinical Information

Initial Request for Hetlioz – Non-24 Sleep-Wake Disorder: (answer questions 1-5)

1. Is the beneficiary at least 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.)
   ___ If the assessment of at least one physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for >/= 1 week plus evaluation of sleep logs recorded for >/= 1 month.
4. Has the beneficiary had an insufficient response or intolerance to at least two (2) other medications, over-the-counter or prescription, for sleep? Yes___ No___
5. Is this medication being prescribed by, or is the physician consulting with, a physician who specialized in the treatment of sleep disorders? Yes___ No___

Initial Request for Hetlioz – Nighttime Sleep Disturbances in Smith-Magenis Syndrome (SMS): (answer questions 6-10)

6. Is the beneficiary at least 16 years of age or older? Yes___ No___
7. Does the beneficiary have a documented diagnosis of Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)? Yes___ No___
8. Has the beneficiary had an insufficient response or intolerance to at least two (2) other medications, over-the-counter or prescription, for sleep? Yes___ No___
10. Is this medication being prescribed by, or is the physician consulting with, a physician who specialized in the treatment of sleep disorders? Yes___ No___

Initial Request for Hetlioz LQ – Nighttime Sleep Disturbances in Smith-Magenis Syndrome (SMS): (answer questions 11-14)

11. Is the beneficiary between 3 years and 15 years of age? Yes___ No___
12. Does the beneficiary have a documented diagnosis of Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)? Yes___ No___
13. Has the beneficiary had an insufficient response or intolerance to at least two (2) other medications, over-the-counter or prescription, for sleep? Yes___ No___
14. 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 Treatment: (answer questions 15 & 16 below)

15. Has the beneficiary used Hetlioz or Hetlioz LQ continuously without gaps in treatment for the initial approval period of three (3) months? Yes___ No___
16. 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 and 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.

Fax to: 1-833-727-3741 or Call PerformRx for help: 1-888-846-1062