HETLIOZ PRIOR AUTHORIZATION REQUEST FORM

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Optum Rx®

United Healthcare® Community Plan

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

PA Requirements for Hetlioz (tasimelteon)

Initial Authorization
Select ONE of the following:

1) Member is 18 years of age or older and has a diagnosis of non-24-hour sleep-wake disorder ☐ Yes ☐ No
   - Member is confirmed to have total blindness (documentation must be submitted) ☐ Yes ☐ No
   - Member has had at least 3 months of persistent non-24 hours sleep-wake disorder symptoms (e.g., difficulty sleeping at night, difficulty initiating or staying asleep, etc.) (documentation must be submitted) ☐ Yes ☐ No
   - Prescriber attests that member's symptoms are not better explained by another current sleep, medical, neurologic, mental, or substance use disorder, or from medication use ☐ Yes ☐ No
   - Please provide requested dose per day: _____

2) Member is 16 years of age or older and has a diagnosis of nighttime sleep disturbances secondary to Smith-Magenis syndrome ☐ Yes ☐ No
   - Member has had genetic testing confirming Smith-Magenis syndrome (documentation must be submitted) ☐ Yes ☐ No
   - Nighttime sleep disturbances experienced by member (e.g., frequent nighttime awakenings, shortened and fragments sleep cycles, etc.) have been documented and submitted with this request ☐ Yes ☐ No
   - Please provide requested dose per day: _____

Reauthorization

Please submit documentation (e.g., current and previous chart notes) showing positive response or stabilization in sleep-wake disorder OR sleep disturbances

- Please provide requested dose per day: _____

PA Requirements for Hetlioz LQ (tasimelteon suspension)

Initial Authorization

Member is 3 years of age or older and less than 16 years of age with a diagnosis of nighttime sleep disturbances secondary to Smith-Magenis syndrome ☐ Yes ☐ No

- Member has had genetic testing confirming Smith-Magenis syndrome (documentation must be submitted) ☐ Yes ☐ No
- Nighttime sleep disturbances experienced by member (e.g., frequent nighttime awakenings, shortened and fragments sleep cycles, etc.) have been documented and submitted with this request ☐ Yes ☐ No
- Please provide requested dose per day: _____
- Please provide member's weight (kg or lb) (include date of collection): _____

Reauthorization

Please submit documentation (e.g., current and previous chart notes) showing positive response or stabilization in sleep disturbances

- Please provide requested dose per day: _____
- Please provide member's weight (kg or lb) (include date of collection): _____