

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay the authorization process.

Drug Requested: **Hetlioz[®]** (tasimelteon) (*Non-Preferred*) **(MEDICAID)**

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Quantity Limit: 1 tablet per day

Length of Authorization: 6 months. **Renewals:** must document therapeutic benefit and confirm compliance.

CLINICAL CRITERIA: The following criteria **MUST** be met to ensure the authorization process will **NOT** be delayed.

- For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24)

AND

- Member is completely blind

AND

- Member must be \geq 18 years old

AND

- Patient has tried and failed at least 30 days of zolpidem.

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

UPDATED/REVISED: 7/1/2018