OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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)**

DRUG INFORMATION: Complete 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 authorization 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 ≥ 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: ~~6/29/2017;~~ ~~8/1/2017;~~ **8/22/2018**;