OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 information below. If incomplete, 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 or the authorization process will 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**;