OPTIMA HEALTH PLAN

PHARMACY/MEDICAL 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 authorization process.***

Drug Requested: **Hetlioz®** (tasimelteon)

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

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

***CLINICAL CRITERIA*: *ALL* information below *MUST* be checked to qualify or authorization process will be delayed. Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing to include imaging, nerve conduction studies, lab values) *MUST* be submitted with this request.**

***Initial Approval* – Length is for *6 months*. Quantity limit of 30 capsules/30 days.**

- ❑ **Prescriber is or in consultation with a specialist in sleep disorders.**
- ❑ Member is ≥ 18 years of age
- ❑ Member has diagnosis of non-24-hour-sleep-wake disorder
- ❑ Member has no other concomitant sleep disorder such as sleep apnea or insomnia
- ❑ Member is totally blind and has no light perception in both eyes (nonfunctioning retinas)
- ❑ Member has a history of contraindication or intolerance to melatonin or ramelteon (Rozerem®) therapy
  - ❑ Describe the contradiction or intolerance: _____

_____

OR

- ❑ Member has history of failure of at least 6 months of uninterrupted daily treatment with melatonin or ramelteon (Rozerem®). ***Failure***: Member did not achieve entrainment, clinically meaningful or significant increases in nighttime sleep or decreases in daytime sleep.

  Dates of melatonin or ramelteon therapy: _____

  (Therapy with melatonin or ramelteon (Rozerem®) will be verified through pharmacy paid claims or submitted chart notes.)

***Reauthorization Approval* – Length is for *12 months*. Quantity limit of 30 capsules/30 days./**

- ❑ **Prescriber is or in consultation with a specialist in sleep disorders.**
- ❑ Member is ≥ 18 years of age
- ❑ Member has diagnosis of non-24-hour-sleep-wake disorder
- ❑ Member has no other concomitant sleep disorder such as sleep apnea or insomnia
- ❑ Member is totally blind and has no light perception in both eyes (nonfunctioning retinas)
- ❑ Member had a continuous use of Hetlioz® without any gaps in treatment (filled the prescription to have enough medication for at least 28.5 days or more for each month)
- ❑ Member has a positive clinical response to Hetlioz® therapy with increased total nighttime sleep and/or decreased daytime nap duration

(signature on next page)

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 11/16/2017
REVISED/UPDATED: 3/28/2018