Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Hetlioz® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Non-24-hour sleep-wake disorder

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have any other concomitant sleep disorder such as sleep apnea or insomnia? ❑ **Yes** ❑ **No**

Is the patient totally blind (has no light perception)? ❑ **Yes** ❑ **No**

Does the patient have a history of contraindication or intolerance to melatonin or ramelteon (Rozerem) therapy? ❑ **Yes** ❑ **No**

Does the patient have a history of failure of at least 6 months of uninterrupted daily treatment with melatonin or ramelteon (Rozerem) [Patient did not achieve entrainment, clinically meaningful or significant increases in nighttime sleep or decreases in daytime sleep]? ❑ **Yes** ❑ **No**

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

Was Hetlioz prescribed by or in consultation with a specialist in sleep disorders? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, also answer the following:

Has the patient 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)? ❑ **Yes** ❑ **No**

Has the patient had a positive clinical response to Hetlioz therapy with increased total nighttime sleep and/or decreased daytime nap duration? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

Please note: Chart documentation of the above is required to be submitted along with this fax

_____

_____

Hetlioz® Prior Authorization Request Form (Page 2 of 2)

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Chart notes and any lab results MUST be submitted with this request
****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.