



Hetlioz capsules (tasimelteon) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:	

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://magellanrx.com/member/external/commercial/common/doc/en-us/phi_disclosure_authorization.pdf)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Non-24-Hour Sleep-Wake Disorder (Non-24) <input type="checkbox"/> Smith-Magenis (17p11.2 deletion) Syndrome <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Clinical Information: Is the drug going to be used in conjunction with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Hetlioz (tasimelteon) being prescribed by a sleep specialist or a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>For Initial Request of Non-24-Hour Sleep-Wake Disorder, answer the following:</u> Is patient totally blind? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have a history of insomnia, excessive daytime sleepiness, or both, which alternate with asymptomatic episodes? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient's symptoms of insomnia and/or excessive daytime sleepiness persisted over the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Do daily sleep logs AND actigraphy monitoring for at least 14 days demonstrate a pattern of sleep and wake times that delay each day, with a circadian period that is usually longer than 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide chart documentation.</i> Is the patient's sleep disturbance explained by another current sleep disorder, medical or neurological disorder, mental disorder, medication use or substance use disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>For Initial Request of Smith-Magenis Syndrome, answer the following:</u> Does patient have a confirmed clinical diagnosis of Smith-Magenis (17p11.2 deletion) Syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submitted genetic analysis report is required.</i> Does patient have a history of sleep disturbances? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide chart documentation.</i>		
Renewal Request: Is the patient responding to treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide chart documentation.</i>		





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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:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

