Neighborhood Health Plan OF RHODE ISLAND™

Hetlioz Prior Auth Form
Fax 1-866-423-0945
Pharmacy Dept. Phone 401-427-8200

This form is to be used by participating physicians and providers to obtain coverage. Please complete the form by providing all of the following information. Fax the completed form to Neighborhood at **1-866-423-0945**. For real time Coverage Determination decisions, please go to Cover My Meds: https://www.covermymeds.com/epa/caremark/.

Hetlioz (tasimelteon) Prior Authorization Form

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Important Note: Expedited Decisions
If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. ☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS**

Prescriber's Information		
Name and NPI		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information			
Medication:	Strength and Route of Administration:		Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:	

Criteria Questions			
1	Does the member have a diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas)? If yes, must attach supporting clinical documentation of diagnosis.	Yes	No
2	Is the member able to perceive light in either eye?	Yes	No
3	Is the member experiencing difficulty initiating sleep, difficulty awakening in the morning, or excessive daytime sleepiness?	Yes	No
4	Does the member have a confirmed clinical diagnosis of Smith-Magenis syndrome with a history of sleep disturbances? If yes, must attach supporting clinical documentation of diagnosis.	Yes	No
5	Is this for continuation of therapy? If yes, please supply date therapy initiated: _____ If no, no further questions	Yes	No
6	For continuation in Non-24-Hour Sleep-Wake Disorder, has the member experienced an increase in total nighttime sleep and/or decreased daytime nap duration? [Submit clinical documentation] For continuation in sleep disturbances in Smith-Magenis Syndrome, has the member experienced an improvement in quality of sleep (e.g., improvement in sleep efficiency, sleep onset and final sleep offset, or waking after sleep onset)? [Submit clinical documentation]	Yes	No

After filling out the questionnaire, if there is any additional clinical information that you would like to provide, please indicate below:

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_____

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I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature: _____ NPI: _____ Date: _____