

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Medicare Part B Medicare Part D
 This request is: Expedited request Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Hetlioz[®] (tasimelteon)

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
 Provider Address: _____
 Provider NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____ Sleep specialist

Product Information

New Request Continuation Request
 Drug product: Hetlioz 20 mg capsule
 Date of last dose (if applicable): _____
 Dosing frequency: _____
 Start date (or date of next dose): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Patient must have Non-24-Hour Sleep-Wake disorder
2. Must be prescribed by a sleep specialist or neurologist

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

New request

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- Non-24-Hour Sleep-Wake disorder (Non-24)
- Other – the patient's condition is: _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? Yes No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Hetlioz likely be the most effective option for this patient?

No

Yes, because: _____

If the patient is currently using Hetlioz, would changing the patient's current regimen likely result in adverse effects for the patient?

No

Yes, because: _____
