

SENTARA HEALTH PLAN

PHARMACY 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; **(Pharmacy) 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: (select drug below)

☐ **tasimelteon (Hetlio^z®) Capsules**

☐ **Hetlio^z® (tasimelteon) Liquid**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Quantity Limit: 30 capsules/30 days, or if ≤ 28 kg: 0.7 mg/kg/dose once daily

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

☐ **For diagnosis of non-24-hour-sleep-wake disorder**

- ☐ Prescribed by or in consultation with a specialist in sleep disorders
- ☐ Member is ≥ 18 years of age
- ☐ Member has a 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)

(Continued on next page)

- ☐ Member has a history of contraindication or intolerance to melatonin or ramelteon (Rozerem®) therapy (please submit chart notes)

OR

- ☐ Member has history of failure of at least 6 months of uninterrupted daily treatment with melatonin or ramelteon (Rozerem®). Failure is defined as inability to 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.)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

☐ **For diagnosis of Smith-Magenis syndrome**

- ☐ The provider is a specialist experienced in treating patients diagnosed with Smith-Magenis Syndrome [i.e., sleep specialist, developmental/behavioral provider]
- ☐ The provider confirms a diagnosis of Smith-Magenis Syndrome (SMS) by all of the following:
 - ☐ Submission of documentation detailing symptomology confirming SMS, and not due to another medical diagnosis (i.e., trisomy 21, Williams syndrome, brachydactyly-intellectual deficit syndrome (del 2q37), Prader-Willi syndrome)
 - ☐ Submission of the results from a genetic panel confirming a deletion at chromosome 17p11.2 OR variant involving RAI1
 - ☐ Submission of detailed history, progress notes, and/or actigraphy focusing on pattern of sleep disturbances affecting the patient (quality, average sleep time)
- ☐ For Hetlioz LQ™, the patient is between 3 and 15 years of age and documentation of current weight and requested dose must be submitted and follow FDA-approved dosing guidelines

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****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.****