OPTIMA 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: Hetlioz® (tasimelteon)

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)
- ❑ 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.)

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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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 11/16/2017
REVISED/UPDATED: ~~3/28/2018; (Reformatted) 6/14/2019; 4/23/2021; 6/30/2021;~~ **Reformatted 2/9/2022**;