SENTARA COMMUNITY PLAN
(MEDICAID)

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; **fax to 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: (Check below the drug that applies)

❑ **Hetlioz™** (tasimelteon) ❑ **Hetlioz™ LQ (tasimelteon) suspension**	❑ **tasimelteon** (generic **Hetlioz™**)

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:** _____

Weight: _____ **Date:** _____

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**

- ❑ Member is ≥ 16 years of age

(Continued on next page)

- ❑ Member has a diagnosis of non-24-hour-sleep-wake disorder
- ❑ Member has no other concomitant sleep disorder such as sleep apnea or insomnia
- ❑ If requesting brand Hetlioz™: member has trial and failure to generic tasimelteon ❑Yes ❑No

❑ For diagnosis of Smith-Magenis syndrome

- ❑ The provider confirms a diagnosis of Smith-Magenis Syndrome (SMS)
- ❑ 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

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.