Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Hetlioz - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Has the patient been previously approved for Hetlioz®?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of Non-24-Hour Sleep-Wake Disorder?

☐ Yes ☐ No

Q3. Does the patient have improvement in nighttime sleep time or reduction in daytime naptime compared to baseline documented per sleep log or diary?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of Smith-Magens Syndrome (SMS)?

☐ Yes ☐ No

Q5. Does the patient have improvement in sleep disturbances including difficulty falling asleep, problems staying asleep, and frequent awakenings at night as documented per chart notes?

☐ Yes ☐ No

Q6. Does the patient have a diagnosis of complete blindness?

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of Non-24-Hour Sleep-Wake Disorder classified indicated by actigraphy or sleep log or diary?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q8. Is baseline nighttime sleep time and daytime naptime documented per sleep log or diary attached?

☐ Yes ☐ No

Q9. Does the patient have a diagnosis of Smith-Magens Syndrome (SMS) confirmed by genetic testing? Please attach genetic testing results.

☐ Yes ☐ No

Q10. Does the patient have sleep disturbances including difficulty falling asleep, problems staying asleep, and frequent awakenings at night? Please attach chart notes documenting symptoms.

☐ Yes ☐ No

Q11. Is the patient 3 years of age or older? For patients age 3 to 15 years old, is the patient prescribed Hetlioz® LQ oral suspension or if the patient is 16 years of age or older, is the patient prescribed Hetlioz® capsules?

☐ Yes ☐ No

Q12. Has the patient been prescribed Hetlioz® by or in consultation with a sleep specialist, psychiatrist or neurologist?

☐ Yes ☐ No

Q13. Requested Duration:

☐ 12 months

Q14. Additional Information:

Prescriber Signature

Date

2023 Medicare Prior Authorization Request