AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Tasimelteon (Hetlioz®)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for tasimelteon (Hetlioz®). Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered under the following conditions: 1) Patient has a diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as confirmed by a sleep specialist; and 2) Patient is 18 years of age or older; and 3) Documentation the patient is totally blind with no perception of light is provided; and 4) Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and 5) Patient has a documented trial and therapy failure with ramelteon (Rozerem®). If criteria for coverage are met, initial requests will be approved for 3 months. Requests for continuation of therapy will be considered when the patient has received 3 months of continuous therapy and patient has achieved adequate results with tasimelteon (Hetlioz®), such as entrainment, significant increase in nighttime sleep, and/or significant decreases in daytime sleep.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred:

☐ **Hetlioz®**

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Has diagnosis been confirmed by a sleep specialist? ☐ Yes (attach documentation) ☐ No

Is patient totally blind with no perception of light? ☐ Yes (attach documentation) ☐ No

Treatment failure with a preferred sedative/hypnotic-non-benzodiazepine agent:

Drug name and dose: Trial dates: Reason for failure:

Treatment failure with ramelteon (Rozerem®):

Drug name and dose: Trial dates: Reason for failure:

Possible drug interactions/conflicting drug therapies:

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Requests for continuation therapy:

Has patient received 3 months of continuous tasimelteon (Hetlioz®) therapy? ☐ Yes ☐ No

Has patient achieved adequate results with tasimelteon (Hetlioz®) therapy? ☐ Yes (describe below) ☐ No

Patient improvements with tasimelteon (Hetlioz®) therapy (include description):

☐ Entrainment: _____

☐ Significant increase in nighttime sleep: _____

☐ Significant decrease in daytime sleep: _____

☐ Other: _____

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.