Prior Authorization Request Form for
tasimelteon **(Hetlioz)**

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. **Is the patient totally blind?**	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. **Does the patient have a documented diagnosis of non-24 hour sleep-wake disorder?**	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. **Has the patient had a trial of melatonin and either failed therapy or had an adverse event to therapy?**	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. **Is the patient taking a drug that will interact with Hetlioz, for example, beta blockers or strong CYP3A4 inducers?** *Examples of **strong CYP3A4 inducers**: Banzel (rufinamide), dexamethasone, Fycompa (perampanel), griseofulvin, Intelence (etravirine), modafinil (Provigil), Mycobutin (rifabutin), nafcillin, Onfi (clobazam), oxcarbazepine (Oxtellar XR, Trileptal), phenobarbital, phenytoin (Dilantin), Priftin (rifapentine), primidone (Mysoline), rifampin (Rifadin), St. John's wort, Sustiva (efavirenz), Tegretol (carbamazepine), Tracleer (bosentan), Viramune (nevirapine), Xtandi (enzalutamide), Zelboraf (vemurafenib).* *Examples of **beta blockers**: atenolol (Tenormin), betaxolol (Kerlone), bisoprolol (Zebeta), metoprolol (Lopressor, Toprol XL), nadolol (Corgard), nebivolol (Bystolic), propranolol (Inderal), sotalol (Betapace), timolol.*	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

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5. **Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Hetlioz*	☐ Yes (subject to verification) Proceed to question **6**	☐ No **Sign and date below**
6. **Has the patient been receiving Hetlioz for 6 months and has a documented response to therapy?**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_______________________________ Prescriber Signature

_____________ Date

[31 July 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: