

**Montana Healthcare Programs Prior Authorization Request Form
for Use of Hetlioz™ (tasimelteon)**

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty (if applicable):	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:**☐ INITIATION OF THERAPY**

Please check appropriate diagnosis and complete corresponding information:

1. Non-24-Hour Sleep-Wake Disorder

- a. Member is 18 years of age or older: ☐ Yes ☐ No
- b. Medication is prescribed by or in consultation with a sleep specialist: ☐ Yes ☐ No

Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

Name of specialist: _____ Contact date: _____

- c. Member has a diagnosis of Non-24-Hour Sleep-Wake Disorder with supporting sleep diaries attached:
☐ Yes ☐ No
- d. Member must have documented functional impairment due to Non-24-Hour Sleep-Wake Disorder:
☐ Yes ☐ No

Action required: Provider must submit documentation explaining the functional impairment.

- e. Other therapies (timed melatonin or planned social/physical activities) have been inadequate:
☐ Yes ☐ No

Action required: Please provide information on what all has been trialed: _____

2. Smith-Magenis Syndrome (SMS)

- a. Member is ≥ 3 years of age: ☐ Yes ☐ No
- b. Medication is prescribed by or in consultation with a sleep specialist: ☐ Yes ☐ No

Action required: If not in a specialty clinic or written by a specialist, information on annual consult with an appropriate specialist is required:

Name of specialist: _____ Contact date: _____

- c. Member has a diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS):
☐ Yes ☐ No
- d. Other therapies (timed melatonin or planned social/physical activities) have been inadequate:
☐ Yes ☐ No

Action required: Please provide information on what all has been trialed: _____

- e. Laboratory results are **attached**, confirming member has either microdeletions or mutations of the RAI1 gene: ☐ Yes ☐ No

LIMITATIONS:

Non-24-Hour Sleep-Wake Disorder: Maximum daily dose is 20mg per day.

Smith-Magenis Syndrome (SMS):

- Weight < 28kg, dose is 0.7mg/kg - oral suspension is only approved for members 3-15 years of age.
- For weight > 28kg, the maximum daily dose is 20mg per day.

Initial authorization will be issued for 6 months.

☐ CONTINUATION OF THERAPY

1. Non-24-Hour Sleep-Wake Disorder

- a. Provider attests to positive clinical outcomes as evidenced by sleep diaries (e.g., increase in number of hours slept or decrease in the number of worst nights slept), AND the sleep diaries are attached for review: ☐ Yes ☐ No
- b. Annual specialty consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – provider is the specialist.

2. Smith-Magenis Syndrome (SMS)

- a. Provider attests to positive clinical outcomes as evidenced by sleep diaries (e.g., increase in number of hours slept or decrease in the number of worst nights slept), AND the sleep diaries are attached for review: ☐ Yes ☐ No
- b. Annual specialty consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – provider is the specialist.

Reauthorization will be issued for 12 months.

Please complete form, including required attachments and fax to:

Drug Prior Authorization Unit at 1-800-294-1350