Sleep Disorder Agents – Hetlioz (tasimelteon)

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? _____**

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

United Healthcare Community Plan

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1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation of a positive clinical response from baseline [e.g., improved sleep quality, decreased nighttime awakening, increased sleep time, maintain regular or improved sleep intervals]? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Non-24-Hour Sleep-Wake Disorder (N24SWD) in adults
   ☐ Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)
   ☐ Other. Specify: _____

3. Is this prescribed by or in consultation with a psychiatrist, neurologist, or sleep specialist? ☐ Yes ☐ No

For diagnosis of Non-24-Hour Sleep-Wake Disorder (N24SWD) in adults:

4. Does patient have any of the following (check all that apply):
   ☐ History of insomnia or excessive daytime sleepiness alternating with asymptomatic episodes
   ☐ Symptoms have persisted for at least 3 months
   ☐ Documentation of gradually shifting sleep-wake times demonstrated by daily sleep logs or actigraphy for at least 14 consecutive days

5. Is the patient blind in both eyes without light perception? ☐ Yes ☐ No

For diagnosis of Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS):

6. Has patient's diagnosis of SMS been confirmed by one of the following?
   ☐ A heterozygous deletion of RAI1 on chromosome 17p11.2
   ☐ Presence of a pathogenic variant involving RAI1 on chromosome 17p11.2

7. Does the patient have documentation of sleep disturbances (e.g frequent nocturnal arousals, early morning awakenings, daytime sleep attacks, inability to fall asleep)? ☐ Yes ☐ No

8. Does the patient have a history of failure contraindication, or intolerance to the following: (check all that apply)
   ☐ A beta-1 selective blocker (e.g., acebutolol)
   Specify drug: _____
   ☐ An additional medication used to promote sleep (e.g., ramelteon, clonidine, trazodone, diphenhydramine etc.)
   Specify drug: _____

REQUIRED WITH THIS REQUEST

Chart notes

For SMS:

- Diagnostic testing
- Documentation of sleep disturbance

For N24SWD:

- Sleep logs or actigraphy if applicable

Prescriber signature	Prescriber specialty	Date