

HETLIOZ PRIOR AUTHORIZATION REQUEST FORM



OptumRx
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Today's Date

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Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # <input style="width: 100%;" type="text"/>	Date of Birth <input style="width: 100%;" type="text"/>
Patient's Name <input style="width: 100%;" type="text"/>	Prescriber's Name <input style="width: 100%;" type="text"/>
Prescriber's IN License # <input style="width: 100%;" type="text"/>	Specialty <input style="width: 100%;" type="text"/>
Prescriber's NPI # <input style="width: 100%;" type="text"/>	Prescriber's Signature <input style="width: 100%;" type="text"/>
Return Fax # <input style="width: 100%;" type="text"/>	Return Phone # <input style="width: 100%;" type="text"/>
Check box if requesting retro-active PA <input type="checkbox"/>	Date(s) of service requested for retro-active eligibility (if applicable): <input style="width: 100%;" type="text"/>

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

PA Requirements for Hetlioz

Please provide member's diagnosis:

- Non-24-hour sleep-wake disorder
- Nighttime sleep disturbances in patients with Smith-Magenis syndrome
- Other: _____

Member weight: _____

Requested dosage form and daily dose:

- Capsules; Daily Dose: _____
- Suspension; Daily Dose: _____

If the request is for the suspension, do any of the following apply?

- Member is under 18 years of age
- Member is unable to swallow capsule formulation
- Other justification for use over capsules: _____

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