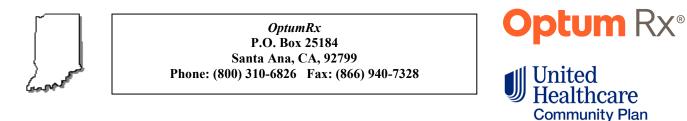
## HETLIOZ PRIOR AUTHORIZATION REQUEST FORM



Today's Date								
	/		/					

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

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

Patient's Medicaid #	Date of Birth		
Patient's Name	Prescriber's Name		
Prescriber's IN License #	Specialty		
Prescriber's NPI #	Prescriber's Signature		
Return Fax #	Return Phone # - - -		
Check box if requesting retro-active PA	Date(s) of service requested for retro-active eligibility (if applicable):		

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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