UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for

Hetlioz/Hetlioz LQ

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____ Provider Fax #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (In days): Initial Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days

Re-authorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

HETLIOZ (complete questions 1-6 for Helioz)

1. Is the beneficiary 18 years old or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a documented diagnosis of Non-24 sleep-wake disorder? ☐ **Yes** ☐ **No**
3. The diagnosis of Non-24 sleep-wake disorder is confirmed by meeting ONE of the following conditions:
   - ☐ Assessment of at least one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset [as measured in blood or saliva], assessment of core body temperature
   - ☐ Assessment of at least one physiologic circadian phase marker cannot be done, the diagnosis must be confirmed By actigraphy performed for >/= 1 week plus evaluation of sleep logs recorded for >/= 1 month
4. Is the beneficiary 16 years old or older? ☐ **Yes** ☐ **No**
5. Does the beneficiary have a diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)? ☐ **Yes** ☐ **No**

HETLIOZ LQ (complete questions 7-8 for Hetlioz LQ)

7. Is the beneficiary between 3 years and 15 years of age? ☐ **Yes** ☐ **No**
8. Does the beneficiary have a diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)? ☐ **Yes** ☐ **No**

Hetlioz and Hetlioz LQ: (complete questions 9-10)

9. Has the beneficiary had an insufficient response or intolerance to at least two (2) other medications for sleep? (can be over-the-counter or prescription) ☐ **Yes** ☐ **No**
10. Is this medication being prescribed by, or is the physician consulting with, a physician who specialized in the treatment of sleep disorders? ☐ **Yes** ☐ **No**

Re-authorization for Hetlioz and Heltioz LQ: (complete questions 11-12)

11. Has the beneficiary used Hetlioz/Hetlioz LQ continuously without gaps in treatment for the initial approval period of three (3) months? ☐ **Yes** ☐ **No**
12. As the provider, have you included an objective evaluation of the beneficiary's sleep quality, including documentation of an improvement in overall sleep quality while taking Hetlioz/Hetlioz LQ? ☐ **Yes** ☐ **No**

**Documentation of the beneficiary's overall sleep quality improvement must accompany this reauthorization for Hetlioz/Hetlioz LQ. **

Signature of Prescriber:_____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593