

# HETLIOZ

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

**Today's Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today's Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Please select the patient's diagnosis:

- Non-24-hour sleep-wake disorder
- Smith-Magenis Syndrome (SMS)
- Other (ICD code, plus description): \_\_\_\_\_

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

1. Is the patient currently treated with the requested agent? .....  Yes  No
2. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., sleep specialist, neurologist, psychiatrist) or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No
3. Is the patient's age within FDA labeling for the requested indication for the requested agent? .....  Yes  No  
If no, please give rationale in support of using the requested agent for the patient's age for the requested indication: \_\_\_\_\_
4. Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No
5. Is the requested quantity (dose) greater than the maximum FDA labeled dose for the requested indication? .....  Yes  No  
If yes, please give rationale in support of therapy with a higher dose for the requested indication: \_\_\_\_\_
6. Can the requested quantity (dose) be achieved with a lower quantity of a higher strength? .....  Yes  No  
If no, please explain: \_\_\_\_\_

**For non-24-hour sleep-wake disorder requests:**

7. Is the patient totally blind (i.e., no light perception)? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

**For Smith-Magenis Syndrome (SMS) requests:**

8. Was the patient's diagnosis confirmed by the presence of ONE of the following genetic mutations:  
 1) heterozygous deletion of 17p11.2, or 2) a heterozygous pathogenic variant involving RAI1?.....  Yes  No  
 If yes, please specify: \_\_\_\_\_
9. Is the requested agent being used to treat nighttime sleep disturbances associated with SMS?.....  Yes  No

**For renewal requests:**

10. Has the patient had clinical benefit with the requested agent?.....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

**CONFIDENTIALITY NOTICE:** This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.