Prescriber Criteria Form

Hetlioz 2025 PA Fax 1125-A v2 010125.docx
Hetlioz (tasimelteon capsule)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Hetlioz (tasimelteon capsule).

Drug Name:
Hetlioz (tasimelteon capsule)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of non-24-hour sleep-wake disorder? [If no, then skip to question 7.]	Yes ◯	No ◯
2	Is the patient 18 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas)? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient able to perceive light in either eye? [If yes, then no further questions.]	Yes ◯	No ◯
5	Is patient currently receiving therapy with the requested medication? [If no, then skip to question 13.]	Yes ◯	No ◯
6	Does the patient meet at least one of the following criteria: A) the patient is experiencing increased total nighttime sleep, B) the patient is experiencing decreased daytime nap duration? [If yes, then skip to question 12.] [If no, then no further questions.]	Yes ◯	No ◯

7	Does the patient have a diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)? [If no, then no further questions.]	Yes ◯	No ◯
8	Does the patient have a confirmed diagnosis of Smith-Magenis Syndrome (SMS)? [If no, then no further questions.]	Yes ◯	No ◯
9	Is the patient 16 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
10	Is the patient currently receiving therapy with the requested medication? [If no, then skip to question 13.]	Yes ◯	No ◯
11	Is the patient experiencing improvement in the quality of sleep since starting therapy? Note: Quality of sleep may be determined by sleep efficiency, sleep onset and final sleep offset, waking after sleep onset. [If no, then no further questions.]	Yes ◯	No ◯
12	Is the requested drug being prescribed by or in consultation with a sleep disorder specialist, neurologist, or psychiatrist? [No further questions.]	Yes ◯	No ◯
13	Is the requested drug being prescribed by or in consultation with a sleep disorder specialist, neurologist, or psychiatrist?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____