WellCare
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NC Medicaid and NC Health Choice Pharmacy
Prior Approval Request for Hetlioz / Hetlioz LQ

Beneficiary Information

1. Beneficiary Last Name:_____2. Beneficiary First Name:_____
3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Beneficiary Sex:_____

Prescriber Information

6. Prescribing Provider NPI #:_____
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 1-5 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. Is the diagnosis of non-24 sleep-wake disorder 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], or assessment of core body temperature).
   - ☐ If assessment of at least one physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for at least one week or longer, plus evaluation of sleep logs recorded for at least one month or longer.
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 6-7 for Hetlioz LQ)

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

(Cont.)

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Hetlioz and Hetlioz LQ: (complete questions 8-9)

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

Re-authorization for Hetlioz and Heltioz LQ: (complete questions 10-11)

10. Has the beneficiary used Hetlioz / Hetlioz LQ continuously without gaps in treatment for the initial approval period of three months? ☐ **Yes** ☐ **No**
11. 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. **

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.

Signature of Prescriber:_____Date:_____

(Prescriber Signature Mandatory)

Fax this form to **1-800-678-3189**
Pharmacy PA Call Center: **1-866-799-5318**