coordinated care

Sleep Disorder Agents – Hetlioz (tasimelteon)

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation of a positive clinical response from baseline [e.g., improved sleep quality, decreased nighttime awakening, increased sleep time, maintain regular or improved sleep intervals]? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Non-24-Hour Sleep-Wake Disorder (N24SWD) in adults
   ☐ Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)
   ☐ Other. Specify: _____

3. Is this prescribed by or in consultation with a psychiatrist, neurologist, or sleep specialist? ☐ Yes ☐ No

For diagnosis of Non-24-Hour Sleep-Wake Disorder (N24SWD) in adults:

4. Does patient have any of the following (check all that apply):
   ☐ History of insomnia or excessive daytime sleepiness alternating with asymptomatic episodes
   ☐ Symptoms have persisted for at least 3 months
   ☐ Documentation of gradually shifting sleep-wake times demonstrated by daily sleep logs or actigraphy for at least 14 consecutive days

5. Is the patient blind in both eyes without light perception? ☐ Yes ☐ No

For diagnosis of Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS):

6. Has patient's diagnosis of SMS been confirmed by one of the following?
   ☐ A heterozygous deletion of RAI1 on chromosome 17p11.2
   ☐ Presence of a pathogenic variant involving RAI1 on chromosome 17p11.2

7. Does the patient have documentation of sleep disturbances (e.g frequent nocturnal arousals, early morning awakenings, daytime sleep attacks, inability to fall asleep)? ☐ Yes ☐ No

8. Does the patient have a history of failure contraindication, or intolerance to the following: (check all that apply)
   ☐ A beta-1 selective blocker (e.g., acebutolol)
   Specify drug: _____
   ☐ An additional medication used to promote sleep (e.g., ramelteon, clonidine, trazodone, diphenhydramine etc.)
   Specify drug: _____

REQUIRED WITH THIS REQUEST

Chart notes

For SMS:

- Diagnostic testing
- Documentation of sleep disturbance

For N24SWD:

- Sleep logs or actigraphy if applicable

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)