

**PRIOR AUTHORIZATION REQUEST FORM**

**Medicare Part D Hetlioz  
(tasimelteon)**

**Phone: 800-728-7947 Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note, any information left blank or illegible may delay the review process.

<b>Patient Name:</b>	<b>Prescriber Name: Supervising Physician:</b>	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. What diagnosis is this drug being prescribed for? <input type="checkbox"/> Non-24 hour sleep-wake disorder <input type="checkbox"/> Other
Q2. Please provide ICD code(s) for diagnosis
Q3. Is prescribing physician a sleep specialist or working in consultation with a sleep specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Is prescribing physician a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Additional comments:

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\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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