

**2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM**



Tasimelteon - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

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

<p>Q1. Has the patient been previously approved for Tasimelteon?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Does the patient have a diagnosis of Non-24-Hour Sleep-Wake Disorder?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Does the patient have improvement in nighttime sleep time or reduction in daytime naptime compared to baseline documented per sleep log or diary?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Does the patient have a diagnosis of Smith-Magens Syndrome (SMS)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Does the patient have improvement in sleep disturbances including difficulty falling asleep, problems staying asleep, and frequent awakenings at night as documented per chart notes?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<p>Q6. Does the patient have a diagnosis of complete blindness?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q7. Does the patient have a diagnosis of Non-24-Hour Sleep-Wake Disorder classified indicated by actigraphy or sleep log or diary?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q8. Is baseline nighttime sleep time and daytime naptime documented per sleep log or diary attached?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q9. Does the patient have a diagnosis of Smith-Magens Syndrome (SMS) confirmed by genetic testing? Please attach genetic testing results.</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q10. Does the patient have sleep disturbances including difficulty falling asleep, problems staying asleep, and frequent awakenings at night? Please attach chart notes documenting symptoms.</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q11. Is the patient 3 years of age or older? For patients age 3 to 15 years old, is the patient prescribed Hetlioz LQ oral suspension or if the patient is 16 years of age or older, is the patient prescribed Tasimelteon capsules?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q12. Has the patient been prescribed Tasimelteon by or in consultation with a sleep specialist, psychiatrist or neurologist?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q13. Requested Duration:</p> <p><input type="checkbox"/> 12 Months <span style="margin-left: 200px;"><input type="checkbox"/> Other:</span></p>	

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Q14. Additional Information:
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Prescriber Signature

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Date

2024 Medicare Prior Authorization Request