Reset Form Print Form

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Hetlioz®/Hetlioz LQ™

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

SECTION III: CLINICAL HISTORY

1. Does the patient have non-24-hour sleep-wake disorder? ☐ Yes ☐ No
2. Has the patient had an adequate trial and failure or intolerance to at least 2 medications for sleep? ☐ Yes ☐ No

   If *yes*, please list treatment failures and provide dates or concurrent treatment:

   _____
3. Does the patient have a diagnosis of Smith-Magenis syndrome (SMS)? ☐ Yes ☐ No
4. Is the medication being prescribed by or in consultation with a physician specializing in sleep disorders? ☐ Yes ☐ No

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.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-866-675-7755
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Review Date: 01/29/2024

Magellan Rx MANAGEMENT℠