CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
HETLIOZ PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____

PA Requirements for Hetlioz:

Diagnosis Code: _____

Please provide the member's diagnosis:

- ☐ Non-24-hour sleep-wake disorder
- ☐ Nighttime sleep disturbances in patients with Smith-Magenis syndrome
- ☐ Other: _____

Member weight: _____

Requested dosage form and daily dose:

- ☐ Capsules; Daily Dose: _____
- ☐ Suspension; Daily Dose: _____

If the request is for the suspension, do any of the following apply?

- ☐ Member is under 18 years of age
- ☐ Member is unable to swallow capsule formulation
- ☐ Other justification for use over capsules: _____

I attest that the provided information above is accurate:

Physician Signature: _____ **Date:** _____