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

MDwise
Fax to: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131
Phone: (800) 788-2949

MDwise
A McLaren Company

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

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

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

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

PA Requirements for Hetlioz

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: _____