PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Non-24-hour sleep-wake disorder (Non-24) (If checked, go to 2) ☐
   - Nighttime sleep disturbances in Smith-Magenis syndrome (SMS) (If checked, go to 8) ☐
   - Other, please specify: (If checked, no further questions) ☐

   _____
2. Is the requested drug prescribed by or in consultation with a sleep specialist (e.g., neurologist experienced with sleep disorders, physician certified in sleep medicine) or psychiatrist? **Y** ☐ **N** ☐
3. Does the patient have a diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas)? ACTION REQUIRED: If Yes, please attach chart notes or test results confirming diagnosis.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
4. Is the patient able to perceive light in either eye? **Y** ☐ **N** ☐
5. Is the patient currently receiving therapy with Hetlioz? **Y** ☐ **N** ☐
6. Is the patient experiencing increased total nighttime sleep and/or decreased daytime nap duration since starting requested drug? ACTION REQUIRED: If Yes, please attach supporting documentation.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
7. Is the patient experiencing difficulty initiating sleep, difficulty awakening in the morning, or excessive daytime sleepiness? **Y** ☐ **N** ☐
8. Is the requested drug prescribed by or in consultation with a sleep specialist (e.g., neurologist experienced with sleep disorders, physician certified in sleep medicine) or psychiatrist? **Y** ☐ **N** ☐
9. Does the patient have a confirmed clinical diagnosis of Smith-Magenis syndrome? ACTION REQUIRED: If Yes, please attach chart notes or test results confirming diagnosis.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
10. Does the patient have a history of sleep disturbances? **Y** ☐ **N** ☐
11. Is the patient currently receiving therapy with the requested drug? **Y** ☐ **N** ☐

12. Is the patient experiencing improvement in the quality of sleep such as improvement in sleep efficiency, sleep onset and final sleep offset, or waking after sleep onset since starting therapy? ACTION REQUIRED: If Yes, please attach supporting documentation.
ACTION REQUIRED: Submit supporting documentation

Y ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date