



**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:

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FIRST NAME:

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MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

GENDER:

☐ Male

☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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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: _____

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