



**New Hampshire AIDS Drug Assistance 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:

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

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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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:

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PHONE NUMBER:

				-					-										
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FAX NUMBER:

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**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: \_\_\_\_\_