US Family Health Plan
Prior Authorization Request Form for
tasimelteon **(Hetlioz)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization will expire in 6 months for initial approvals; indefinite approval for continuation of therapy

Step 1

Please complete patient and physician information (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

Question		
1. **Is the patient totally blind?**	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. **Does the patient have a documented diagnosis of non-24 hour sleep-wake disorder?**	☐ Yes Proceed to question 3	☐ No **STOP** Coverage not approved
3. **Has the patient had a trial of melatonin and either failed therapy or had an adverse event to therapy?**	☐ Yes Proceed to question 4	☐ No **STOP** Coverage not approved
4. **Is the patient taking a drug that will interact with Hetlioz, for example, beta blockers or strong CYP3A4 inducers?** *Examples of* ***strong CYP3A4 inducers****: Banzel (rufinamide), dexamethasone, Fycompa (perampanel), griseofulvin, Intelence (etravirine), modafinil (Provigil), Mycobutin (rifabutin), nafcillin, Onfi (clobazam), oxcarbazepine (Oxtellar XR, Trileptal), phenobarbital, phenytoin (Dilantin), Priftin (rifapentine), primidone (Mysoline), rifampin (Rifadin), St. John's wort, Sustiva (efavirenz), Tegretol (carbamazepine), Tracleer (bosentan), Viramune (nevirapine), Xtandi (enzalutamide), Zelboraf (vemurafenib).* *Examples of* ***beta blockers****: atenolol (Tenormin), betaxolol (Kerlone), bisoprolol (Zebeta), metoprolol (Lopressor, Toprol XL), nadolol (Corgard), nebivolol (Bystolic), propranolol (Inderal), sotalol (Betapace), timolol.*	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 5

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5. **Is the request for continuation therapy?**	☐ Yes Proceed to question 6	☐ No Sign and date below
6. **Has the patient been receiving Hetlioz for 6 months and has a documented response to therapy?**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature ______________________ Date ____________