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

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 855-273-5735

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**

Initial and renewal prior authorization expires after 6 months. For renewal of therapy an initial USFHP prior authorization approval is required.

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:**

1. The provider acknowledges that Hetlioz capsules are not approved for pediatrics or adolescents and are not approved for treating Smith-Magenis Syndrome (SMS); and that Hetlioz LQ liquid is only approved for pediatrics with SMS and is not approved for Non-24 sleep wake disorder or for use in adults.	☐ Acknowledged Proceed to question **2**	
2. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Hetlioz.*	☐ Yes (subject to verification) Proceed to question **3**	☐ No Proceed to question **4**
3. Has the patient been receiving Hetlioz/Hetlioz LQ for 6 months and has a documented response to therapy?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
4. What is the requested medication?	☐ Hetlioz LQ Proceed to question **5**	☐ Hetlioz capsules Proceed to question **6**
5. Is the patient between 3 years of age and 15 years of age?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
6. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved

USFHP Prior Authorization Request Form for
tasimelteon **(Hetlioz, Hetlioz LQ)**

7. Does the patient have a documented diagnosis of Smith-Magenis Syndrome (SMS)? **Note: Non-FDA-approved uses are not approved including jet lag disorder or other circadian rhythm disorders.**	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
8. Is the patient totally blind?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Does the patient have a documented diagnosis of non-24 hour sleep-wake disorder? **Note: Non-FDA-approved uses are not approved including jet lag disorder or other circadian rhythm disorders.**	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Has the patient had a trial of melatonin and either failed therapy or had an adverse event to therapy?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
11. Has the patient tried and failed ramelteon?	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
12. 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 **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____