

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):

1 Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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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.	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes (subject to verification) Proceed to question 3	<input type="checkbox"/> No Proceed to question 4
3. Has the patient been receiving Hetlioz/Hetlioz LQ for 6 months and has a documented response to therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
4. What is the requested medication?	<input type="checkbox"/> Hetlioz LQ Proceed to question 5	<input type="checkbox"/> Hetlioz capsules Proceed to question 6
5. Is the patient between 3 years of age and 15 years of age?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
6. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved

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<p>7. Does the patient have a documented diagnosis of Smith-Magenis Syndrome (SMS)?</p> <p>Note: Non-FDA-approved uses are not approved including jet lag disorder or other circadian rhythm disorders.</p>	<p style="text-align: center;"><input type="checkbox"/> Yes Proceed to question 10</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>8. Is the patient totally blind?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes Proceed to question 9</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>9. Does the patient have a documented diagnosis of non-24 hour sleep-wake disorder?</p> <p>Note: Non-FDA-approved uses are not approved including jet lag disorder or other circadian rhythm disorders.</p>	<p style="text-align: center;"><input type="checkbox"/> Yes Proceed to question 10</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>10. Has the patient had a trial of melatonin and either failed therapy or had an adverse event to therapy?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes Proceed to question 11</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>11. Has the patient tried and failed ramelteon?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes Proceed to question 12</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>12. Is the patient taking a drug that will interact with Hetlioz, for example, beta blockers or strong CYP3A4 inducers? <i>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.</i></p>	<p style="text-align: center;"><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p style="text-align: center;"><input type="checkbox"/> No Sign and date below</p>

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

_____ Prescriber Signature

_____ Date