Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Hetlioz and Hetlioz LQ/ tasimelteon

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): Initial Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days
   Re-authorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

HETLIOZ and tasimelteon (complete questions 1-5 for Hetlioz and tasimelteon)

1. Is the member 18 years old or older? ☐ **Yes** ☐ **No**
2. Does the member have a documented diagnosis of Non-24 sleep-wake disorder? ☐ **Yes** ☐ **No**
3. The diagnosis of Non-24 sleep-wake disorder is confirmed by meeting ONE of the following conditions:
   ☐ Assessment of at least one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset [as measured in blood or saliva], assessment of core body temperature
   ☐ Assessment of at least one physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for >/= 1 week plus evaluation of sleep logs recorded for >/= 1 month
4. Is the member 16 years old or older? ☐ **Yes** ☐ **No**
5. Does the member have a diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)?
   ☐ **Yes** ☐ **No**

HETLIOZ LQ (complete questions 6-7 for Hetlioz LQ)

6. Is the member between 3 years and 15 years of age? ☐ **Yes** ☐ **No**
7. Does the member have a diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)?
   ☐ **Yes** ☐ **No**

Hetlioz and Hetlioz LQ: (complete questions 8-9)

8. Has the member had an insufficient response or intolerance to at least two (2) other medications for sleep? (can be over-the-counter or prescription) ☐ **Yes** ☐ **No**
9. Is this medication being prescribed by, or is the physician consulting with, a physician who specialized in the treatment of sleep disorders? ☐ **Yes** ☐ **No**

Re-authorization for Hetlioz and Hetlioz LQ: (complete questions 10-11)

10. Has the member used Hetlioz/Hetlioz LQ continuously without gaps in treatment for the initial approval period of three (3) months? ☐ **Yes** ☐ **No**
11. As the provider, have you included an objective evaluation of the member's sleep quality, including documentation of an improvement in overall sleep quality while taking Hetlioz/Hetlioz LQ? ☐ **Yes** ☐ **No**
    **Documentation of the member's overall sleep quality improvement must accompany this reauthorization for Hetlioz/Hetlioz LQ. **

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

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.