Member Name: ______________________________ Member ID: _______________ Member DOB: _______________

Drug Name: _____________________________ Strength: _______________ Directions: _____________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ___________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

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Horizon NJ Health

Tasimelteon (Hetlioz, Hetlioz LQ) – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

For Hetlioz (capsules) requests:

1. What is the diagnosis?

   □ Non-24-Hour Sleep-Wake Disorder

   □ Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)

   □ Other: ____________________________________

2. Has the member tried melatonin?

   □ Yes:
   1. How long was melatonin tried for?: ____
   2. Why can't the member continue using melatonin?: ___________________________

   □ No:
   1. Can the member try melatonin?:
      □ Yes – Please notify the pharmacy of the change and return the form.

      □ No – Please let us know the reason why: _____________________________

3. Does the member have any other concomitant sleep disorder (e.g., sleep apnea, insomnia)?

   □ Yes

   □ No

For Hetlioz LQ (liquid) requests:

1. What is the diagnosis?

   □ Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)

   □ Other: ____________________________________

Physician office's signature*_________________________________ Print Name________________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

*****Complete page 2 only for Subsequent/Renewal requests*****

1. What is the diagnosis?

□ Non-24-Hour Sleep-Wake Disorder

□ Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)

□ Other: _______________________________________

2. Is there documentation of positive clinical response to treatment?

□ Yes

□ No

Physician office's signature*________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**