Member Name: _____________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: _________________________ Physician Phone #: ________________________ Specialty: ____________________

Physician Fax#: _____________________ Pharmacy Name: ____________________________ Pharmacy Phone: _________________

Horizon NJ Health

Tasimelteon (Hetlioz, Hetlioz LQ) – Medical Necessity Request

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

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Non-24-Hour Sleep-Wake Disorder (Non-24)

1. Is the member totally blind with no perception of light?
   - □ Yes
   - □ No

□ Smith-Magenis Syndrome (SMS)

1. Does the member have nighttime sleep disturbances?
   - □ Yes
   - □ No

□ 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*****

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Non-24-Hour Sleep-Wake Disorder (Non-24)

1. Has the member demonstrated response to therapy? **Yes** or **No**
   - If **Yes**, the member responded to therapy by:
     - □ Increased nighttime sleep time
     - □ Decreased daytime nap time
     - □ Other:____

□ Smith-Magenis Syndrome (SMS)

1. Has the member demonstrated response to therapy? **Yes** or **No**
   - If **Yes**, the member responded to therapy by:
     - □ Increased nighttime sleep time
     - □ Improvement in nighttime sleep quality
     - □ Other:____

□ Other: ____

Physician office's signature*_________________________________ Print Name________________________________

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