

SPECIALTY GUIDELINE MANAGEMENT

HETLIOZ (tasimelteon)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication

Hetlioz is indicated for the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Non-24-Hour Sleep-Wake Disorder

Authorization of 3 months may be granted to members who are initiating Hetlioz therapy when BOTH of the following criteria are met:

- A. The member has a diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas).
- B. The member is NOT able to perceive light in either eye.

III. CONTINUATION OF THERAPY

Non-24-Hour Sleep-Wake Disorder

Authorization of 12 months may be granted to members who meet ALL of the following criteria:

- A. The member has a diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas).
- B. The member is NOT able to perceive light in either eye.
- C. The member is experiencing increased total nighttime sleep and/or decreased daytime nap duration.

IV. REFERENCES

1. Hetlioz [package insert]. Washington, D.C.: Vanda Pharmaceuticals, Inc.; December 2014.
2. Auger, Robert R, Burgess, Helen J, et al. Clinical Practice Guideline for the Treatment of Intrinsic Circadian Rhythm Sleep-Wake Disorders: Advanced Sleep-Wake Phase Disorder (ASWPD), Delayed Sleep-Wake Phase Disorder (DSWPD), Non-24-Hour Sleep-Wake Rhythm Disorder (N24SWD), and Irregular Sleep-Wake Rhythm Disorder (ISWRD). An Update for 2015: An American Academy of Sleep Medicine Clinical Practice Guideline. *J Clin Sleep Med* 2015 Oct;11(10):1199-236.