# New Hampshire Medicaid Fee-for-Service Program

# Hetlioz®/Hetlioz LQ™ Criteria

**Approval Date: January 22, 2024**

## Medications

| Brand Name | Generic Name | Dosage Strengths |
|---|---|---|
| Hetlioz® | tasimelteon | 20 mg capsules |
| Heltioz LQ™ | tasimelteon | 4 mg/mL suspension (48 mL and 158 mL) |

## Criteria for Approval

1. Diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24); **AND**
2. Patient is ≥ 18 years of age; **AND**
3. Patient has had an insufficient response or intolerance to at least 2 medications for sleep; **OR**
4. Diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS); **AND**
5. Patient is ≥ 16 years of age (Hetlioz®) or ≥ 3 years of age (Hetlioz LQ™); **AND**
6. The medication is prescribed by, or in consultation with a physician who specializes in the treatment of sleep disorders.

## Criteria for Denial

1. Prior approval will be denied if the approval criteria are not met

**Length of Authorization:** One year

## Dosing

1. Non-24 – Hetlioz® 20 mg/day
2. SMS –
   a. age ≥ 16 years – Hetlioz® 20mg/day
   b. age ≥ 3 years – Hetlioz LQ™ ≤ 28 kg – 0.7 mg/kg/day; > 28 kg – 20 mg/day

## References

Available upon request.

## Revision History

| Reviewed by | Reason for Review | Date Approved |
|---|---|---|
| DUR Board | New | 12/02/2021 |
| Commissioner Designee | New | 01/14/2022 |
| DUR Board | Revision | 06/02/2022 |
| Commissioner Designee | Approval | 07/12/2022 |
| DUR Board | Revision | 12/08/2023 |
| Commissioner Designee | Approval | 01/22/2024 |