New Hampshire Medicaid Fee-for-Service Program
Hetlioz®/Hetlioz LQ™ Criteria

Approval Date: June 5, 2025

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**
   a. Patient is ≥ 18 years of age; **AND**
   b. Patient has had an insufficient response or intolerance to at least 2 medications for sleep; **OR**
2. Diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS); **AND**
   a. Patient is ≥ 16 years of age (Hetlioz®) or ≥ 3 years of age (Hetlioz LQ™); **AND**
3. 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
DUR Board	Revision	04/08/2025
Commissioner Designee	Approval	06/05/2025