Prescription & Enrollment Form

Hetlioz® (tasimelteon) | Hetlioz LQ™ (tasimelteon) —

Department of Veterans Affairs (VA) ONLY

Hetlioz® (tasimelteon) capsules

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name _____

Last name _____ Middle initial _____

Date of birth _____ ❑ Male ❑ Female

Street address _____ Apt# _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

E-mail address _____

Home phone _____ Mobile/cell/work phone _____

Preferred number: ❑ Home ❑ Mobile ❑ OK to leave message

Best time to reach me: ❑ Morning ❑ Afternoon ❑ Evening _____

Patient's primary language: ❑ English ❑ Other If other, please specify _____

Blind: ❑ Yes ❑ No

How would you like to receive information (select one): ❑ Braille ❑ Audio ❑ Print

Authorized representative _____

Relationship to patient _____

Phone number (authorized representative) _____ ❑ OK to leave message

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____

If NP or PA, under direction of Dr. _____

Office contact name and title _____

Office contact e-mail _____

Office/clinic/institution name _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____

3 CLINICAL INFORMATION

Primary ICD-10 code: ❑ G47.24 CRSD, free-running type (Non-24)

❑ Q93.5/Q93.88 Smith-Magenis Syndrome

Additional supporting information: _____

❑ H54.0 Blindness, both eyes

Pertinent medical history and clinical course _____

❑ NKDA ❑ Known drug allergies _____

Concurrent meds _____

4 VA PHARMACY INFORMATION

(Fill out entirely)

VA Name _____

Street address _____

City _____ State _____ Zip _____

Primary purchasing contact _____

Phone _____ Fax _____

E-mail _____

Secondary purchasing contact _____

Phone _____ Fax _____

E-mail _____

Primary clinical contact _____

Phone _____ Fax _____

E-mail _____

Secondary clinical contact _____

Phone _____ Fax _____

E-mail _____

Purchase order # _____

Shipping Information: ❑ Ship to VA Pharmacy

❑ Ship to patient

Payment Method: ❑ Credit card (call pharmacy contact)

❑ E-Invoice Tungsten Network

5 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
Hetlioz® (tasimelteon) for Adults (Non-24 and SMS)/ Children (SMS) ≥ 16 years old	❑ 20mg capsule	❑ Take 20mg prior to bedtime, at same time every night, without food	Dispense: ❑ 30 day supply ❑ Other _____ Refills _____
Hetlioz LQ™ (tasimelteon) for Children (SMS) 3 to 15 years old	❑ 4 mg/ml oral suspension	❑ Take 1 hour before bedtime at same time every night, without food	Dispense: ❑ 48ml ❑ 158ml ❑ Other_____ Refills _____

Dosing in Children with SMS 3 to 15 years old	
Body Weight ≤ 28kg	Daily Dose (oral suspension), 0.7mg/kg
Body Weight > 28kg	Daily Dose (oral suspension), 20mg/kg

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Dispense as written _____ Date _____ Substitution allowed _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to **(888)-454-8488.** | To reach your team, call toll-free **(888)-454-8860.**

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

VA Ordering Information

Restricted to Specialty Pharmacies or Distributors: Yes

Specialty Pharmacy or Distributor:

Accredo Specialty Pharmacy
Phone: (888)-454-8860 | **Fax:** (888)-454-8488

REMS Components: None

Ordering Details

Hetlioz® (tasimelteon) and Hetlioz LQ™ (tasimelteon) are only available to VA through the designated specialty pharmacy, Accredo Specialty Pharmacy.

The VA prescriber should complete the Hetlioz Prescription & Enrollment Form for the Department of Veterans Affairs and forward the form to the VA pharmacy for review. Once reviewed, the pharmacy should fax the document along with a purchase order number included on the form to Accredo Specialty Pharmacy (888)-454-8488. Please only use this VA-specific form as the release of patient information is limited and the operational details are specific to VA.

Accredo Specialty Pharmacy must call the VA pharmacy for a dispensing and payment authorization, including a purchase order number, before shipping each refill. If a purchase order number is not obtained, payment has not been authorized.

Accredo will then fax a delivery confirmation summary (including the Veteran's name, name of medication, NDC, quantity, date shipped, date received and confirmation/tracking number) to the VA pharmacy within 72 hours for those prescriptions shipped directly to the patient.

Accredo Specialty Pharmacy does not require an account application.