Clinical Policy: Tasimelteon (Hetlioz)

Reference Number: IL.PMN.104
Effective Date: 1.1.20
Last Review Date: 1.22.24
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Tasimelteon (Hetlioz® Hetlioz LQ™) is a melatonin receptor agonist.

FDA Approved Indication(s)

Hetlioz is indicated for treatment of:

- Non-24-hour sleep-wake disorder (non-24) in adults
- Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) in patients 16 years of age and older.

Hetlioz LQ is indicated for the treatment of nighttime sleep disturbances in SMS in pediatric patients 3 to 15 years of age.

Tasimelteon* is indicated for the treatment of Non-24-hour sleep-wake disorder (non-24) in adults.

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**Generic capsule formulation*

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Hetlioz is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Non-24-Hour Sleep-Wake Disorder (must meet all)**:**

1. Diagnosis of non-24-hour sleep-wake disorder;
2. Request is for Hetlioz capsules;
3. Age ≥ 18 years
4. Prescribed by or in consultation with a specialist in sleep disorders;
5. Member has total blindness (e.g., nonfunctioning retinas);
6. Member is unable to perceive light in both eyes;
7. Dose does not exceed 20 mg (1 capsule) per day.

Approval duration:
Medicaid – 12 months

B. Nighttime sleep disturbances in Smith-Magenis Syndrome (must meet all)**:**
1. Diagnosis of SMS confirmed by genetic testing (e.g., deletion 17p11.2 or RAI1 mutation);
2. Prescribed by or in consultation with a specialist in sleep disorders;
3. One of the following (a or b):
   a. Request is for Hetlioz capsules and member is ≥ 16 years old;
   b. Request is for Hetlioz LQ and member is 3 to 15 years of age;
4. Request is for treatment of nighttime sleep disturbances;
5. Dose does not exceed one of the following (a or b):
   a. Hetlioz: 20 mg (1 capsule) per day;
   b. Hetlioz LQ: 0.7 mg per kg per day if weight ≤ 28 kg, 20 mg per day if weight > 28 kg.

Approval duration:
Medicaid – 12 months

C. Other diagnoses/indications (must meet 1 or 2):
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All FDA-Approved Indications (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. Hetlioz: 20 mg (1 capsule) per day;

b. Hetlioz LQ: 0.7 mg per kg per day if weight ≤ 28 kg, 20 mg per day if weight > 28 kg.

Approval duration:
Medicaid – 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
SMS: Smith-Magenis Syndrome

Appendix B: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Hetlioz	Non-24-hr-sleep-wake disorder, nighttime sleep disturbances in SMS	20 mg PO QD one hour before bedtime, at the same time each night	20 mg/day
Hetlioz LQ	Nighttime sleep disturbances in SMS	Weight ≤ 28 kg: 0.7 mg per kg per day PO Weight > 28 kg: 20 mg per day	See dosing regimen

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Dose should be given one hour before bedtime, at the same time each night	
tasimelteon	Non-24-hr-sleep wake disorder	20 mg PO QD one hour before bedtime, at the same time every night	20 mg/day

VI. Product Availability

Capsule (Hetlioz): 20 mg
Oral suspension (Hetlioz LQ): 4 mg/mL (158 mL) bottle

VII. References

1. Hetlioz Prescribing Information. Washington, D.C.: Vanda Pharmaceuticals Inc.; December 2020. Available at: www.hetlioz.com. Accessed October 11, 2022.
2. Auger RR, Burgess HJ, Emens JS, Deriy LV, Thomas SM, and Sharkey KM. 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. J Clin Sleep Med. 2015; 11(10): 1199-1236.
3. Williams WP 3rd, McLin DE 3rd, Dressman MA, Neubauer DN. Comparative review of approved melatonin agonists for the treatment of circadian rhythm sleep-wake disorders. Pharmacotherapy. 2016 Sep;36(9):1028-41.
4. PRISMS Professional Advisory Board. Medical management guidelines for an individual diagnosed with SMS. Approved January 24, 2018. Available at: https://www.prisms.org/wp-content/uploads/pdf/mmg/PRISMS_Medical_Management_Guidelines2018.pdf. Accessed September 27, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created, adapted CP.PMN.104 Tasimelteon (Hetlioz) policy.	12.10.19	
1Q 2020 annual review: no significant changes; references reviewed and updated.	12.31.19	1.7.20
2Q2021 annual review and changes: added- for non-24 added age 18 or older and requirement that request is for Hetlioz per updated prescribing information; added Hetlioz LQ and new indication for nighttime sleep disturbances in SMS. References reviewed and updated.	4.14.2021	
2Q2022 Annual Review: clarified that request for non-24 must be for capsules; references reviewed and updated.	06.14.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2024 Annual Review: Template changes applied to other diagnoses/indications and continued therapy section; Description updated.	1.22.24	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.