MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 29, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

The DHCFP is proposing revisions to Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs, to revise the current clinical criteria for Hetlioz® (tasimelteon).

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective December 5, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL N/A MSM 1200 - Prescribed Drugs	MTL N/A MSM 1200 - Prescribed Drugs

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
APPENDIX A, SECTION III	**Hetlioz® (tasimelteon)**	Revised clinical criteria for the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24) and nighttime sleep disturbances in Smith-Magenis Syndrome (SMS). Removed non-working hyperlinks from the section.

III. Hetlioz® (tasimelteon)

Therapeutic Class: Sedative Hypnotic
Last Reviewed by the DUR Board: April 28, 2022

Hetlioz® (tasimelteon) is subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. For treatment of Non-24-Hour Sleep-Wake Disorder (Non-24).

1. Approval will be given if all following criteria are met and documented:

a. The recipient has a diagnosis of Non-24 disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome); and

~~b. The recipient is totally blind (has no light perception); and~~

~~c.~~b. The medication is being prescribed by or in consultation with a sleep specialist; and

~~d.~~c. The recipient had an adverse reaction, contraindication, or an inadequate response (after at least three months ~~four weeks~~ of therapy) to a therapeutic dose of melatonin.

2. Recertification Request:

a. Documentation of positive clinical response to therapy.

3. Prior Authorization Guidelines:

a. Initial prior authorization will be approved for six months.

b. Recertification will be approved for 12 months.

~~c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx~~

b. For the treatment for nighttime sleep disturbances in Smith-Magenis Syndrome (SMS).

1. Approval will be given if all criteria are met and documented:

a. The recipient has a diagnosis of SMS; and

b. The recipient is at least 16 years of age and older (3 through 15 years of age for LQ suspension); and

c. The recipient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking); and

d. Prescribed by a neurologist or a specialist in sleep disorder; and

e. The recipient had an adverse reaction, contraindication, or an inadequate response (after at least three months ~~four weeks~~ of therapy) to a therapeutic dose of melatonin.

2. Recertification Request:

a. Documentation of positive clinical response to therapy (i.e., improvement in nighttime total sleep time, improvement in nighttime sleep quality).

3. Prior Authorization Guidelines:

a. Initial Prior Authorization will be approved after six months.

b. Recertification will be approved after 12 months.

c. ~~Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.~~