Prescription & Enrollment Form

Hetlioz® (tasimelteon) — Department of Veterans Affairs (VA) ONLY

accredo®

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's name _____

Date of birth _____ ❑ Male ❑ Female

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Work phone _____ Cell phone _____

Evening phone _____ E-mail address _____

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

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Date medication needed _____

Prescriber's name and title _____

If NP or PA, under direction of Dr. _____

Office contact and title _____

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)
❑ H54.0 Blindness, both eyes

Pertinent medical history and clinical course _____

_____

❑ NKDA ❑ Known drug allergies _____

_____

Concurrent meds _____

_____

How to fill a Hetlioz® (tasimelteon) prescription in the Department of Veterans Affairs (VA)

1) Prescriber completes patient prescription form
2) Prescriber sends prescription to the VA Pharmacy
   The following information must be filled in:
   i. Rx must include VA address (Name, Street, City, State, Zip)
   ii. Rx must include VA Pharmacy contact information (Name, Phone and Fax #)
3) VA Pharmacy faxes the form, including prescription, to: Accredo at 888.454.8488
4) Prescriber advises patient that a representative from Accredo will be in contact
5) Accredo specialty pharmacist conducts patient education
6) Accredo ships Hetlioz® to the VA Pharmacy or directly to the patient
7) If shipped to a pharmacy, VA Pharmacy gives Hetlioz® to VA patient
8) Accredo faxes delivery confirmation summary to ordering pharmacy within 72 hours for prescriptions shipped directly to the patient

4 VA PHARMACY NAME (Fill out entirely)

VA Name _____

Street address _____

City _____ State _____ Zip _____

VA Pharmacist Name _____

Phone _____ Fax _____

Purchase order # _____

Shipping Information:

❑ Ship to VA Pharmacy ❑ Ship to patient

5 PATIENT AUTHORIZATION

I authorize the VA Pharmacy to act on my behalf for the purposes of transmitting this prescription to Accredo and receiving the medication:

_____

Date _____

6 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
Hetlioz® (tasimelteon)	❑ 20 mg capsule	❑ Take 20 mg prior to bedtime, at same time every night	Dispense: ❑ 1-month supply ❑ Other _____ Refills _____

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

PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____

Date Substitution allowed Date Dispense as written

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. Have you heard about the new Accredo Prescriber Website? You can check the status of prescriptions and track shipments for all of your Accredo patients. Go to https://prescribers.accredo.com and click "Help" to register.

Please fax completed form to 888.454.8488. To reach your team, call toll-free 888.454.8860.

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