SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Narcolepsy Medications

Drug Requested: (check box below that applies)

Preferred Medications	
❑ **armodafinil tablet** (generic for Nuvigil™) 50 mg, 150 mg, 200 mg, 250 mg	❑ **modafinil** (generic for Provigil®) 100 mg, 200 mg
❑ **Sunosi**™(solriamfetol) 75 mg, 150 mg* *(Requires trial and failure of armodafinil or modafinil)	
Non-Preferred Medications	
❑ **Nuvigil**™ 50 mg, 150 mg, 200 mg, 250 mg	❑ **Provigil**® 100 mg, 200 mg
❑ **Wakix**® 4.45 mg, 17.8 mg	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

1. Is the member 18 years of age or older*?
   - ❑ Yes ❑ No
2. Please check which diagnosis member has.
   - ❑ Narcolepsy **(sleep study must be attached)**
   - ❑ Excessive daytime sleepiness (EDS) in members with narcolepsy **(member is 6 years of age or older for Wakix)***
   - ❑ Obstructive sleep apnea **(sleep study must be attached)**
   - ❑ Sudden onset of weak or paralyzed muscles (cataplexy)
   - ❑ Shift work sleep disorder **(please answer questions 3-6)**
3. Please provide the member's current shift schedule

   Current shift schedule: _____
4. Member's shift work sleep disorder does not occur during the course of another sleep disorder or mental disorder?
   - ❑ Yes ❑ No
5. Member's shift work sleep disorder is not due to the direct physiological effects of a medication or a general medical condition?
   - ❑ Yes ❑ No
6. List any other notes related to shift work sleep disorder that is pertinent.

   _____

   _____

   _____

   _____

   _____

List Pharmaceutical Drugs Attempted and Outcome:

_____

_____

_____

_____

_____

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Medical Necessity: Provide clinical evidence that the Preferred drug(s) will not provide adequate benefit and/or provide clinical rationale for quantity exception requests.

_____

_____

_____

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_____

Preferred Medications

For Sunosi (solriamfetol):

1. Has the member tried and failed either modafinil or armodafinil? ❑ Yes ❑ No

Non-Preferred Medications

For Wakix (pitolisant):

1. Does the member have an International Classification of Sleep Disorders (ICSD-3) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis of narcolepsy?
   ❑ Yes ❑ No
2. Does the member have a baseline daytime sleepiness as measured by a validated scale? (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)?
   ❑ Yes ❑ No
3. Does the member have a mean sleep latency of ≤ 8 minutes AND ≥ 2 sleep onset REM periods (SOREMPs) are found on a mean sleep latency test (MSLT) performed according to standard techniques (A SOREMP [within 15 minutes of sleep onset] on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT)?
   ❑ Yes ❑ No
4. Does the member have cerebrospinal fluid (CSF) hypocretin-1 concentration that has not been measured
   ❑ Yes ❑ No

   OR

5. Does the member have CSF hypocretin-1 concentration measured by immunoreactivity that is either > 110 pg/mL OR > 1/3 of mean values obtained in normal subjects with the same standardized assay?
   ❑ Yes ❑ No
6. Does the member have hypersomnolence and/or MSLT findings that are not better explained by other causes such as insufficient sleep, obstructive sleep apnea, delayed sleep phase disorder, or the effect of medication or substances or their withdrawal?
   ❑ Yes ❑ No

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7. Does patient have daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for ≥ 3 months?
   ❑ Yes ❑ No
8. Member will not be receiving treatment with sedative hypnotic agents (e.g., zolpidem, eszopiclone, zaleplon, benzodiazepines, barbiturates)?
   ❑ Yes ❑ No
9. Member will not use drugs that prolong the QT interval (e.g., quinidine, procainamide, disopyramide, amiodarone, sotalol, ziprasidone, chlorpromazine, thioridazine, moxifloxacin) concomitantly.
   ❑ Yes ❑ No
10. Member will not use histamine-1 (H1) receptor antagonists (e.g., pheniramine maleate, diphenhydramine, promethazine, imipramine, clomipramine, mirtazapine) concomitantly.
    ❑ Yes ❑ No
11. Member does not have a history of prolonged QTc interval (e.g., QTc interval > 450 milliseconds).
    ❑ Yes ❑ No
12. Therapy will not be utilized in members with severe hepatic impairment (Child-Pugh C).
    ❑ Yes ❑ No
13. Patient does not have end stage renal disease (ESRD) (e.g., GFR < 15mL/minute/1.73^{m2}).
    ❑ Yes ❑ No

For Brand name Nuvigil/Provigil:

1. Has the member tried and failed the preferred generics for the requested products?
   ❑ Yes ❑ No

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Does the member continue to meet initial criteria?
   ❑ Yes ❑ No
2. Does the member report a reduction in excessive daytime sleepiness from pre-treatment baseline?
   ❑ Yes ❑ No
3. Has the member not experienced any treatment related adverse events?
   ❑ Yes ❑ No

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.
Previous therapies will be verified through pha rmacy paid claims or submitted chart notes.