

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 (Non-Preferred)

Drug Requested: (check box below that applies)

Minimum Age of 18 for the following Non-preferred Medications:	
<input type="checkbox"/> armodafinil tablet (generic for Nuvigil™) 50 mg, 150 mg, 200 mg, 250 mg (QD)	<input type="checkbox"/> modafinil (generic for Provigil®) 100 mg, 200 mg (QD or BID)
<input type="checkbox"/> Nuvigil™ 50 mg, 150 mg, 200 mg, 250 mg (QD)	<input type="checkbox"/> Provigil® 100 mg, 200 mg (QD or BID)
<input type="checkbox"/> Sunosi™ (solriamfetol) 75 mg, 150 mg	<input type="checkbox"/> 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: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ Date: _____

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.

☐ Narcolepsy (sleep study must be attached)

(Continued on next page)

- ☐ Excessive daytime sleepiness (EDS) in adult members with narcolepsy (sleep study must be attached)
- ☐ Obstructive Sleep Apnea (sleep study must be attached)
- ☐ Sudden onset of weak or paralyzed muscles (cataplexy)
- ☐ Shift Work Sleep Disorder
 - ☐ Current shift schedule: _____
 - ☐ Does not occur during the course of another sleep disorder or mental disorder
 - ☐ Is not due to the direct physiological effects of a medication or a general medical condition
 - ☐ Other: _____

List Pharmaceutical Drugs Attempted and Outcome:

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

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