MHS PHARMACY BENEFIT
NARCOLEPSY AGENTS PRIOR AUTHORIZATION REQUEST FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.
****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Quantity	Dosing

PA Requirements for Nuvigil (armodafinil):

The member is 18 years of age or older and has one of the following diagnoses:

☐ Bipolar depression in conjunction with appropriate medical intervention(s)
- List any other medical intervention(s) being utilized for bipolar depression (e.g., mood stabilizers):

_____

☐ Narcolepsy with excessive daytime sleepiness

☐ Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)
- List any other medical intervention(s) being utilized for obstructive sleep apnea (e.g., PAP, OPT, etc.)?

_____

☐ Shift work sleep disorder

PA Requirements for Provigil (modafinil):

Select ONE of the following:

1) The member is 6 years of age or older and has one of the following diagnoses:
   - ☐ Attention deficit hyperactivity disorder (ADHD)
   - ☐ Narcolepsy with excessive daytime sleepiness
2) The member is 18 years of age or older and has one of the following diagnoses:
   - ☐ Depression-related fatigue in conjunction with appropriate medical intervention(s)
     - List any other medical intervention(s) being utilized for depression (e.g., antidepressants):
       _____
   - ☐ Idiopathic hypersomnia
   - ☐ Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)
     - List any other medical intervention(s) being utilized for obstructive sleep apnea (e.g., PAP, OPT, etc.)?
       _____
   - ☐ Shift work sleep disorder
   - ☐ Sleep deprivation
   - ☐ Steinert myotonic dystrophy syndrome
   - ☐ Unipolar or bipolar depression in conjunction with appropriate medical intervention(s)
     - List any other medical intervention(s) being utilized for unipolar/bipolar depression (e.g., antidepressants/mood stabilizers):
       _____

PA Requirements for Sunosi (solriamfetrol):

The member is 18 years of age or older and has one of the following diagnoses:

- ☐ Narcolepsy with excessive daytime sleepiness
- ☐ Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)
  - List any other medical intervention(s) being utilized for obstructive sleep apnea (e.g., PAP, OPT, etc.)?
    _____
  - Has the member had a previous trial and failure with any of the following in the past year:
    - ☐ Modafinil Dates of use: _____
    - ☐ Armodafinil Dates of use: _____

  If no, please provide any other medical justification for use: _____

  _____

  _____

  _____

PA Requirements for Wakix (pitolisant):

The member is 18 years of age or older and has one of the following diagnoses:

☐ Narcolepsy with cataplexy or excessive daytime sleepiness

☐ Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)

- List any other medical intervention(s) being utilized for obstructive sleep apnea (e.g., PAP, OPT, etc.)?
  _____
- Has the member had a previous trial and failure with any of the following in the past year:
  - ☐ Modafinil Dates of use: _____
  - ☐ Armodafinil Dates of use: _____

  If no, please document any other medical justification for use: _____

  _____

  _____

  _____

PA Requirements for Xyrem (sodium oxybate):

Initial Authorization

Select ONE of the following:

1) The member is 7 years of age or older and has narcolepsy with cataplexy or excessive daytime sleepiness diagnosis ☐ Yes ☐ No
   - Please provide requested dose per day: _____
   - Please provide member's weight (include date of collection): _____

2) The member is 18 years of age or older and has fibromyalgia diagnosis ☐ Yes ☐ No
   - Has the member had a previous trial and failure with ONE of the following?
     - ☐ Amitriptyline Dates of use: _____
     - ☐ SSRIs Medication name and dates of use: _____
     - ☐ SNRIs Medication name and dates of use: _____
     - ☐ Anticonvulsants (gabapentin, pregabalin) Medication name and dates of use: _____
     - ☐ NSAIDs and APAP Dates of use: _____

     If member has not trialed all of the above agents, please provide medical justification as to why that agent or an agent in that class was not trialed.

     _____

     _____

     _____
   - Please provide requested dose per day: _____

Reauthorization

1) Please provide the following information showing an attempt to decrease dose or trial and failure of an alternative therapy within the past year:
   - Date of dose reduction attempt: _____
   - Original dose member was prescribed:_____
   - Dose member was reduced to: _____
   - Outcomes of dose reduction: _____
   - Trial and failure of an alternative therapy (name of medication, date of trial, and an explanation as to how the member failed):

     _____

     _____

2) Please provide documentation showing continued benefit from the medication (i.e., reduction in frequency of cataplexy, reduction in symptoms of excessive daytime sleepiness, etc.) without significant adverse events (documentation must include most recent chart notes)

PA Requirements for Xywav (calcium/magnesium/potassium/sodium oxybates solution):

Initial Authorization

Select ONE of the following:

1) The member is 7 years of age or older and has narcolepsy with cataplexy or excessive daytime sleepiness diagnosis ☐ Yes ☐ No
   - Please provide requested dose per day: _____
   - Please provide member's weight (include date of collection): _____

2) The member is 18 years of age or older has idiopathic hypersomnia ☐ Yes ☐ No
   - Please provide requested dose per day: _____

Reauthorization

1) Please provide the following information showing an attempt to decrease dose or trial and failure of an alternative therapy within the past year:
   - Date of dose reduction attempt: _____
   - Original dose member was prescribed:_____
   - Dose member was reduced to: _____
   - Outcomes of dose reduction: _____
   - Trial and failure of an alternative therapy (name of medication, date of trial, and an explanation as to how the member failed):

     _____

     _____

2) Please provide documentation showing continued benefit from the medication (i.e., reduction in frequency of cataplexy, reduction in symptoms of excessive daytime sleepiness, etc.) without significant adverse events (documentation must include most recent chart notes)