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						
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				
<u> </u>	PA Requirements for Nuvigil (armodafinil):					
The member is 18 years of age or older and has one of the following diagnoses:						
□ Direter depression in conjun						
 Bipolar depression in conjur List any other mediastabilizers): 	nction with appropriate					
List any other medical	nction with appropriate cal intervention(s) bein	medical intervention(s)				
List any other mediculars and stabilizers. □ Narcolepsy with excessive does not	aytime sleepiness opnea syndrome with i	medical intervention(s)				

PA Requireme	ents for Provigil (modafinil):				
Select ONE of t	~				
1)	The member is 6 years of age or older and has one of the following diagnoses:				
	□ Attention deficit hyperactivity disorder (ADHD)				
2)	□ Narcolepsy with excessive daytime sleepiness 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				
	$\hfill \Box$ 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 Paguirama	unto for Curaci (actriamfatral):				
-	ents for Sunosi (solriamfetrol): 18 years of age or older and has one of the following diagnoses:				
□ Obstruct	osy with excessive daytime sleepiness tive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction priate 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:				
	□ Armodafinil Dates of use:				
	If no, please provide any other medical justification for use:				

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) Ist any other medical intervention(s) being utilized for obstructive sleep apnea (e.g., PAP, OPT, etc.)? Ist any other medical intervention(s) being utilized for obstructive sleep apnea (e.g., PAP, OPT, etc.)? Armodafinil Dates of use:	PA Requireme	ents for Wakix (pito	lisant):		
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	The member is	18 years of age or o	older and has one	of the following diagnoses:	
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	□ Narcole	psy with cataplexy o	r excessive daytim	e sleepiness	
Has the member had a previous trial and failure with any of the following in the past year: Modafinil			•	with residual excessive daytime sleepiness in conjunction	
Modafinil Dates of use:	•				
Armodafini Dates of use:	•	Has the member had a previous trial and failure with any of the following in the past vear:			
If no, please document any other medical justification for use:		□ Modafinil	Dates of use:		
If no, please document any other medical justification for use:		□ Armodafinil	Dates of use:		
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: SNRIs Medication name and dates of use: Anticonvulsants (gabapentin, pregabalin) 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.					
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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: 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.	Initial Authori	zation			
daytime sleepiness diagnosis		•			
Please provide requested dose per day: Please provide member's weight (include date of collection): 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? Dates of use: SSRIs Medication name and dates of use: SNRIs Medication name and dates of use: Anticonvulsants (gabapentin, pregabalin) 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.	1)	_	-		
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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:					
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as to why that agent or an agent in that class was not trialed.		□ NSAIDs	s and APAP	Dates of use:	
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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:		
ľ	Dose member was reduced to:		
1	Outcomes of dose reduction:		
İ	Trial and failure of an alternative therapy (name of medication, date of trial, and an		
İ	explanation as to how the member failed):		
İ			
ľ			
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)		
	significant adverse events (documentation must include most recent chart notes)		
PA Requireme	ents for Xywav (calcium/magnesium/potassium/sodium oxybates solution):		
Initial Authoriz			
	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):		
	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):		
	explanation as to now the member falled).		
			
			

 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)

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