NARCOLEPSY AGENTS PRIOR AUTHORIZATION REQUEST FORM



OptumRx P.O. Box 25184 Santa Ana, CA, 92799 Phone: (800) 310-6826 Fax: (866) 940-7328



Today's Date	the prescribing provide	ler			
		d 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 Nuvigi	•				
PA Requirements for Nuvigi The member is 18 years of age or o	•	the following diagnoses:			
The member is 18 years of age or o	lder and has one of				
The member is 18 years of age or o ☐ Bipolar depression in conjun • List any other medic	Ider and has one of action with appropriat cal intervention(s) be	e medical intervention(s)			
The member is 18 years of age or o Bipolar depression in conjunt List any other medicular stabilizers): Narcolepsy with excessive da Obstructive sleep apnea/hyporowith appropriate medical inter-	Ider and has one of action with appropriate cal intervention(s) be aytime sleepiness opnea syndrome with rvention(s)	e medical intervention(s)			

PA Requirer	nents 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)				
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				
	 □ 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 Requirer	nents for Sunosi (solriamfetrol):				
<u> </u>	18 years of age or older and has one of the following diagnoses:				
□ Narcolep	sy with excessive daytime sleepiness				
	ive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction riate 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):							
Selec	t ONE of	the following	j:				
		mber is 6 years of age or older and has a diagnosis of narcolepsy with cataplexy or excessive sleepiness					
		aber is 18 years of age or older and has a diagnosis of obstructive sleep apnea/hypopnea e with residual excessive daytime sleepiness in conjunction with appropriate medical ion(s)					
	•	List any otl OPT, etc.)	other medical intervention(s) being utilized for obstructive sleep apnea (e.g., PAP, tc.)?				
	•	Has the me	ember had	a previous trial ar	nd failure with any of the following in the past year:		
		□ Modaf	inil	Dates of use: _			
		□ Armod	dafinil	Dates of use: _			
		If no, pleas	se documer	nt any other medi	cal justification for use:		
DA E		manta far	Virgon /	a a dium avuba	Mal.		
	L Authoriz		Ayreiii (s	sodium oxyba	ite).		
initiai		ONE of the	following:				
			_	s of age or older	and has narcolepsy with cataplexy or excessive		
		daytime sle	eepiness di	agnosis □ Yes	□ No		
			•	quested dose per	• • • • • • • • • • • • • • • • • • • •		
	2)				nclude date of collection):		
	 The member is 18 years of age or older and has fibromyalgia diagnosis □ Yes Has the member had a previous trial and failure with ONE of the following? 						
			Amitriptyli	ine	Dates of use:		
			SSRIs		Medication name and dates of use:		
			SNRIs		Medication name and dates of use:		
		□ (ga	Anticonvul abapentin, p		Medication name and dates of use:		
			NSAIDs a	nd APAP	Dates of use:		
					the above agents, please provide medical justification nt in that class was not trialed.		
		 Please 	provide re	quested dose per	day:		

	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 Language and Control of the Contro
		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 Requi		nents for Xywav (calcium/magnesium/potassium/sodium oxybates
Initial Auth		ation
Sel	ect (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:
Reauthoriz		n 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)	frec	ase provide documentation showing continued benefit from the medication (i.e., reduction in quency of cataplexy, reduction in symptoms of excessive daytime sleepiness, etc.) without nificant adverse events (documentation must include most recent chart notes)

Reauthorization

CONFIDENTIAL INFORMATION

This facsimile transmission (and attachments) may contain protected health information from the Indiana Health Coverage Programs (IHCP), which is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.