HIGHMARK WEST VIRGINIA

PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

SUNOSI PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber ID Number		Group Number	
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician Name	Phone		Fax
Physician Address	City	State	Zip Code
Suite / Building	Physician Signature		Date

MEDICATION INFORMATION

Requested Strength: ☐ 75mg ☐ 150mg

Quantity **per Month**

Diagnosis:

CLINICAL CRITERIA

MEDICATION HISTORY

1. Has the patient met step therapy* requirements and experienced therapeutic failure, contraindication, or intolerance to generic Modafinil?
   ☐ Yes ☐ No

2. Has the patient met step therapy* requirements and experienced therapeutic failure, contraindication, or intolerance to generic Armodafinil?
   ☐ Yes ☐ No

3. Has the patient met step therapy* requirements and experienced therapeutic failure, contraindication, or intolerance to a generic CNS stimulant (e.g. dextroamphetamine, methylphenidate)?
   ☐ Yes ☐ No

*If requesting an exemption from step therapy, please provide clinical rationale: _____

_____

_____

_____

4. Please provide any other medications previously tried and failed for the patient's diagnosis:

_____

_____

_____

OBSTRUCTIVE SLEEP APNEA

If the patient has **obstructive sleep apnea**, please answer the following:

1. Is the patient currently receiving and compliant with continuous positive airway pressure (CPAP)?
   ☐ Yes ☐ No
2. Is the patient experiencing any of the following symptoms? Please select **ALL** that apply:
   ☐ Coronary artery disease ☐ Unrefreshing sleep ☐ Mood disorder ☐ Insomnia
   ☐ Congestive heart failure ☐ Cognitive dysfunction ☐ Atrial fibrillation ☐ Fatigue
   ☐ Type 2 diabetes mellitus ☐ Daytime sleepiness ☐ Hypertension ☐ Stroke
   ☐ Unintentional sleep episodes during wakefulness ☐ Waking up holding breath, gasping, or choking
   ☐ Bed partner describes loud snoring, breathing interruptions or both
3. Please provide the following from the patient's **diagnostic** polysomnography:

   Apnea/hypopnea index (AHI) in events/hour: _____

NARCOLEPSY

If the patient has **narcolepsy**, please answer the following:

1. Please provide baseline data of the following:

   Excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS): _____

   Maintenance of Wakefulness Test (MWT): _____
2. Please provide the following results of the patient's multiple sleep latency test (MSLT):

   Mean sleep latency (in minutes): _____

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____
3. Please provide the following from the patient's diagnostic polysomnography:

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____
4. If the patient has hypocretin-1 deficiency, please provide the following:

   Cerebrospinal fluid hypocretin-1 level (in pg/mL): _____

   Cerebrospinal fluid hypocretin-1 laboratory reference range): _____
5. Does the patient have a diagnosis of cataplexy?
   ☐ Yes ☐ No
   a. If **YES**: please provide the baseline number of cataplexy episodes: _____

REAUTHORIZATION

Is this a request for reauthorization? ☐ Yes ☐ No

If **YES**, please select **ALL** that apply:

- ☐ The patient has experienced improvement in daytime sleepiness
- ☐ The patient experienced improvement on the ESS** or MWT*** compared to baseline
- ☐ The patient experienced a decrease in cataplexy episodes compared to baseline
- ☐ The patient is currently receiving and compliant with continuous positive airway pressure (CPAP)

**Epworth Sleepiness Scale
***Maintenance of Wakefulness Test

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222