carolina complete health™

Pharmacy Prior Approval Request for Antinarcolepsy: Sunosi

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days: ___28___
11. Length of Therapy (in days): Initial Authorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days

Reauthorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

1. Is the beneficiary 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have an adequate documented trial and failure of, or contraindication to, Provigil or Nuvigil?
   ☐ **Yes** ☐ **No** Please explain if contraindicated: _____
   _____
3. Does the beneficiary have a diagnosis of obstructive sleep apnea (OSA)? ☐ **Yes** ☐ **No**
4. Does the beneficiary have a diagnosis of narcolepsy? ☐ **Yes** ☐ **No**
5. Does the beneficiary have end stage renal disease (estimated glomerular filtration rate [eGFR] < 15ml/min/1.73m2)?
   ☐ **Yes** ☐ **No**
6. Has the beneficiary's blood pressure been assessed and hypertension controlled (≤ 140/90 mmHg) prior to initiating treatment? ☐ **Yes** ☐ **No**
7. Has the beneficiary received an MAO inhibitor within the previous 14 days? ☐ **Yes** ☐ **No**
8. Is the beneficiary receiving concomitant noradrenergic medications? ☐ **Yes** ☐ **No**
9. Has the beneficiary failed an adequate trial of at least one preferred drug? ☐ **Yes** ☐ **No Please list t/f Medication:**
   _____
10. If using to treat OSA, does the provider attest that the beneficiary is compliant with and will continue using positive airway pressure (PAP)? ☐ **Yes** ☐ **No**
11. If using to treat OSA, has the prescriber excluded any other identifiable causes for beneficiary's sleepiness (e.g. non-compliance with PAP, improperly fitted AP mask, insufficient sleep, poor sleep hygiene, depression, and/or other sleep disorders)? ☐ **Yes** ☐ **No**

For continuation of therapy, please answer questions 1-13

12. Has the beneficiary developed increased blood pressure or heart rate that was not controlled by dose reduction of solriamfetol (Sunosi) or medical intervention? ☐ Yes ☐ No
13. Has the beneficiary reported a documented reduction in excessive daytime sleepiness from pre-treatment baseline as measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)? ☐ **Yes** ☐ **No**

Signature of Prescriber:_____Date:_____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/