CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
NARCOLEPSY AGENTS PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____

Requested Medication	Quantity	Dose	Directions for Use

I attest the information provided on this form is accurate:

Physician Signature: _____ **Date:** _____

PA Requirements for Nuvigil (armodafinil):

Is the member 18 years of age or older? □ Yes □ No

Please provide the member's diagnosis and diagnosis-related information:

- ☐ Narcolepsy
- ☐ Excessive daytime sleepiness
- ☐ Obstructive sleep apnea with residual excessive daytime sleepiness
  - Is the member receiving appropriate medical treatment for obstructive sleep apnea (e.g., PAP, OPT, etc.)? □ Yes (Documentation required) □ No
- ☐ Shift work sleep disorder
- ☐ Bipolar depression
  - Document any other medications being utilized for bipolar depression: _____
- ☐ Other: _____

PA Requirements for Provigil (modafinil):

Is the member 6 years of age or older? □ Yes □ No

Please provide the member's diagnosis and diagnosis-related information:

- ☐ Narcolepsy
- ☐ Excessive daytime sleepiness
- ☐ Obstructive sleep apnea with residual excessive daytime sleepiness
  - Is the member receiving appropriate medical treatment for obstructive sleep apnea (e.g., PAP, OPT, etc.)? □ Yes (Documentation required) □ No
- ☐ Shift work sleep disorder
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Unipolar or bipolar depression
- ☐ Depression-related fatigue
- ☐ Sleep deprivation
- ☐ Steinert Myotonic Dystrophy Syndrome
- ☐ Other: _____

PA Requirements for Sunosi (solriamfetrol):

Is the member 18 years of age or older? □ Yes □ No

Please provide the member's diagnosis and diagnosis-related information:

- ☐ Narcolepsy
- ☐ Obstructive sleep apnea with residual excessive daytime sleepiness
  - 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: _____

- ☐ Other: _____

PA Requirements for Wakix (pitolisant):

Is the member 18 years of age or older? □ Yes □ No

Please provide the member's diagnosis and diagnosis-related information:

- ☐ Narcolepsy
- ☐ Other: _____

PA Requirements for Xyrem (sodium oxybate):

Is the member 7 years of age or older? □ Yes □ No

Please provide the member's diagnosis and diagnosis-related information:

☐ Narcolepsy with cataplexy and/or excessive daytime sleepiness

☐ Fibromyalgia

- Has the member had a previous trial and failure with ALL of the following:

☐ Amlodipine Dates of use: _____

☐ SSRIs Medication and dates of use: _____

☐ SNRIs Medication and dates of use: _____

☐ Anticonvulsants (gabapentin, pregabalin) Medication and dates of use: _____

☐ NSAIDs and acetaminophen Dates of use: _____

If **no,** please document any other medical justification for use as to why not all of the above agents were trialed:

_____

_____

☐ Other: _____

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

Is the member 7 years of age or older? □ Yes □ No

Please provide the member's diagnosis and diagnosis-related information:

☐ Narcolepsy with cataplexy and/or excessive daytime sleepiness

☐ Other: _____