

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



CareSource Pharmacy PA 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.*****

Member's CareSource ID	Member's Date of Birth
Member's Name	Prescriber's Name
Prescriber's Indiana License Number	Specialty
Prescriber's National Provider Identifier (NPI)	Office Contact
Prescriber's Fax	Prescriber's Phone
Prescriber's Address	Date(s) of Service: Start Date:
Diagnosis Description	Diagnosis Code

Requested Medication	Quantity	Dosing

PA Requirements for Nuvigil (armodafinil):

The member is 18 years of age or older and has one of the following diagnoses:

- ☐ Bipolar depression in conjunction with appropriate medical intervention(s)
 - List any other medical intervention(s) being utilized for bipolar depression (e.g., mood stabilizers):

- ☐ Narcolepsy with excessive daytime sleepiness
- ☐ 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

Member's Name: _____

PA Requirements for Provigil (modafinil):

- 1) The member is 6 years of age or older and has one of the following diagnoses:
- ☐ Attention deficit hyperactivity disorder (ADHD)
 - ☐ Narcolepsy with excessive daytime sleepiness
- 2) 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 Requirements for Sunosi (solriamfetol):

The member is 18 years of age or older and has one of the following diagnoses:

- ☐ Narcolepsy with excessive daytime sleepiness
- ☐ 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 Dates of use: _____

Armodafinil Dates of use: _____

If no, please provide any other medical justification for use:

PA Requirements for Wakix (pitolisant):

Select ONE of the following:

- ☐ The member is six years of age or older and has a diagnosis of narcolepsy with cataplexy or excessive daytime sleepiness
- ☐ The member is 18 years of age or older and has a diagnosis of 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 Dates of use: _____

Armodafinil Dates of use: _____

If no, please provide any other medical justification for use:

PA Requirements for Xyrem (sodium oxybate):

Initial Authorization

1. The member is seven 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): _____

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

Initial Authorization

Select ONE of the following:

- 1) The member is seven 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 idiopathic hypersomnia? ☐ Yes ☐ No
 - Please provide requested dose per day: _____

Reauthorization

Note: 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).

CONFIDENTIAL INFORMATION

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at 1-844-607-2831.