Anti Narcolepsy Agents

Armodafinil/modafinil/Sunosi/Wakix

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Indicate the patient's diagnosis
- ☐ Narcolepsy with Excessive Daytime Sleepiness confirmed with a sleep study and multiple sleep latency test
- ☐ Narcolepsy with Cataplexy confirmed with a sleep study and multiple sleep latency test
- ☐ Obstructive Sleep Apnea with Excessive Daytime Sleepiness confirmed with a sleep study
- ☐ Shift Work Sleep Disorder
- ☐ Other. Specify: _____

2. Does patient have a history of failure as stated below, contraindication, or intolerance to any of the following (mark all that apply)
- ☐ Modafinil (Provigil) for a minimum of 60 consecutive days
- ☐ Armodafinil (Nuvigil) for a minimum of 60 consecutive days
- ☐ Amphetamine or methylphenidate-based stimulant for a minimum of 60 consecutive days.
- ☐ Solriamfetol (Sunosi) for a minimum of 30 consecutive days
- ☐ Other contraindication or intolerance. Specify drug and describe: _____

3. Is the medication prescribed by, or in consultation with, a neurologist, psychiatrist, or sleep specialist?
☐ Yes ☐ No

4. Has patient had a quantitative assessment completed within the last 6 months (e.g., Epworth Sleepiness Scale, Maintenance of Wakefulness Test)? ☐ Yes ☐ No

5. Is this request for a continuation of therapy? ☐ Yes ☐ No
If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

For diagnosis of Narcolepsy with Cataplexy, please answer the following:

6. Does patient have clinical documentation that supports any of the following (check all that apply):
- ☐ Presence of cataplexy (e.g., documented episodes of sudden loss of muscle tone)
- ☐ Impairment/limitation of activities of daily living (e.g. unable to attend school, unable to attend work, unable to drive)?

7. For continuation of therapy requests, does patient have clinical documentation showing a reduction in cataplexy events? ☐ Yes ☐ No

For diagnosis of Obstructive Sleep Apnea with Excessive Daytime Sleepiness, please answer the following:

8. Has the patient achieved normalized breathing and oxygenation with continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP)? ☐ Yes ☐ No

9. Does patient have documentation within the past 6 months, demonstrating adherence to any of the following (check all that apply)?

☐ CPAP or BIPAP therapy (CPAP or BIPAP is used for 70% of nights for a minimum of 4 hours per night)
☐ Mandibular advancement device
☐ Other. Specify: _____

For diagnosis of Shift Work Sleep Disorder, please answer the following:

10. Is there clinical documentation demonstrating concomitant use of nonpharmacologic interventions (i.e., counseling, sleep hygiene)? ☐ Yes ☐ No

All requests require chart notes

For diagnosis of narcolepsy, provide the following:

- Sleep study and multiple sleep latency test (MSLT)
- Quantitative assessment within the past 6 months (e.g. Epworth Sleepiness Scale, Maintenance of Wakefulness Test)
- For narcolepsy with cataplexy continuation of therapy requests, provide clinical documentation showing a reduction of cataplexy events.

For diagnosis of obstructive sleep apnea with excessive daytime sleepiness, provide the following:

- Sleep study
- Quantitative assessment within the past 6 months (e.g. Epworth Sleepiness Scale, Maintenance of Wakefulness Test)
- Documentation of adherence to CPAP/BIPAP therapy or mandibular advancement device compliance in the last 6 months

For continuation of therapy, provide clinical documentation demonstrating disease stability or a positive clinical response. For obstructive sleep apnea, documentation of adherence to CPAP/BiPAP or mandibular advancement device is required.

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)