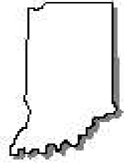
# INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
# NARCOLEPSY AGENTS PRIOR AUTHORIZATION REQUEST FORM



*OptumRx*
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**Phone: (866) 215-5046 Fax: (866) 940-7328**

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

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

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

| | |
|---|---|
| Patient's Medicaid # | Date of Birth __ / __ / ____ |
| Patient's Name | Prescriber's Name |
| Prescriber's IN License # | Specialty |
| Prescriber's NPI # | Prescriber's Signature |
| Return Fax # ___ - ___ - ____ | Return Phone # ___ - ___ - ____ |
| Check box if requesting retro-active PA ☐ | Date(s) of service requested for retro-active eligibility (if applicable): |

*Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).*

| Requested Medication | Quantity | Dosing |
|---|---|---|
| | | |

## 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: ____________________________________

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