HEALTHY U CHIP

# PRIOR AUTHORIZATION REQUEST FORM
## SUNOSI

**For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.**

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

| | | |
|---|---|---|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |
| Height/Weight: | | |

***Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.***

**Product being requested:** ☐ Sunosi® (solfiamfetol)

Dosing/Frequency:_____

**If the request is for reauthorization, proceed to reauthorization section.**

| Questions | Yes | No | Comments/Notes |
|---|---|---|---|
| **EXCESSIVE SOMNOLENCE ASSOCIATED WITH NARCOLEPSY** | | | |
| 1. Is the member 18 years of age or older? | ☐ | ☐ | |
| 2. Does the member have a baseline ESS score of 15 or higher? | ☐ | ☐ | **Please provide documentation** |
| 3. Does the member have a diagnosis of narcolepsy confirmed by polysomnography and MSLT? | ☐ | ☐ | **Please provide documentation** |
| 4. Is Sunosi® prescribed by, or in consultation with, a sleep disorder specialist or neurologist? | ☐ | ☐ | |
| 5. Has the member tried at least one agent from each of the following categories for at least 3 months each:<br>• Central nervous system stimulant (e.g. methylphenidate)<br>• Wakefulness promoting agent (e.g. modafinil) | ☐ | ☐ | **Please provide documentation** |
| 6. Is the member's blood pressure adequately controlled? | ☐ | ☐ | **Please provide documentation** |
| 7. Will the member be monitored for psychologic disorders or exacerbations? | ☐ | ☐ | |
| **EXCESSIVE SOMNOLENCE ASSOCIATED WITH SLEEP APNEA** | | | |
| 1. Is the member 18 years of age or older? | ☐ | ☐ | |
| 2. Does the member have a baseline ESS score of 15 or higher? | ☐ | ☐ | **Please provide documentation** |
| 3. Does the member have a diagnosis of obstructive sleep apnea confirmed by a sleep disorder specialist with either polysomnography, or OCST? | ☐ | ☐ | **Please provide documentation** |

| | | | |
|---|---|---|---|
| 4. Is Sunosi® prescribed by, or in consultation with, a sleep disorder specialist or pulmonologist? | ☐ | ☐ | |
| 5. Is the member being treated with non-pharmacologic primary treatment modalities (CPAP or similar)? | ☐ | ☐ | **Please provide documentation** |
| 6. Is the member at least 90% compliant on non-pharmacologic primary treatment modalities with at least 5 hours of use per night for at least 3 months prior to initiation of Sunosi®? | ☐ | ☐ | |
| 7. Will the member continue to use CPAP therapy for at least 6 hours per night with at least 90% compliance during Sunosi® therapy? | ☐ | ☐ | |
| 8. Has the member tried modafinil or armodafinil for at least 3 months while using CPAP? | ☐ | ☐ | **Please provide documentation** |
| 9. Is the member's blood pressure adequately controlled? | ☐ | ☐ | **Please provide documentation** |
| 10. Will the member be monitored for psychologic disorders or exacerbations? | ☐ | ☐ | |
| **REAUTHORIZATION** | | | |
| 1. Is the request for reauthorization of therapy? | ☐ | ☐ | |
| 2. Does documentation show the member had an improvement in ESS score from baseline?<br>• At least 5 point improvement for initial renewal<br>• Maintenance of ESS score improvement for ongoing renewals | ☐ | ☐ | **Please provide documentation** |
| 3. For OSA, has the member continued to use non-pharmacologic primary treatment modalities with at least 90% compliance for at least 6 hours per night? | ☐ | ☐ | **Please provide documentation** |
| **What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.** | | | |
| Additional information: | | | |
| Physician Signature: | | | |

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-107
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024