HIGHMARK | HIGHMARK

Medication Prior Authorization Form
Fax to 1-866-240-8123

Sunosi

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

Requested Drug and Strength	Requested Quantity	Requested Day Supply
☐ Sunosi 75mg tablet ☐ Sunosi 150mg tablet		☐ 30 days ☐ 90 days ☐ Other: _____
Directions		
Diagnosis and/or ICD-10 code(s)		

Medication History:

1. Has the member experienced therapeutic failure, contraindication, or intolerance to generic Modafinil?	Yes	No
2. Has the member experienced therapeutic failure, contraindication, or intolerance to generic Armodafinil?	Yes	No
3. Has the member experienced therapeutic failure, contraindication, or intolerance to a generic CNS (central nervous system) stimulant (for example, dextroamphetamine, methylphenidate)?	Yes	No
4. Please provide any other medications that the member has tried and failed: _____ _____		

OBSTRUCTIVE SLEEP APNEA

If the requested medication is being used to treat **obstructive sleep apnea**, please answer the following:

1. Is the member currently receiving and compliant with positive airway pressure (PAP)?	Yes	No
2. Has the member experienced therapeutic failure, intolerance, or contraindication to positive airway pressure (PAP)?	Yes	No
3. Is the member currently using and compliant with a custom, titratable oral appliance?	Yes	No
4. Is the member experiencing persistent daytime sleepiness despite adequate obstructive sleep apnea treatment?	Yes	No
5. Have alternative causes of daytime sleepiness been excluded?	Yes	No

6. Please provide the following from the member's **diagnostic** polysomnography, recording time, or home sleep apnea test:

   Apnea/Hypopnea Index (AHI): _____ events per hour

   Respiratory Disturbance index (RDI): _____ events per hour

   Respiratory Event index (REI): _____ events per hour

7. Is the member experiencing any of the following symptoms?
   Please select **ALL** that apply:

   - ☐ Coronary artery disease
   - ☐ Unrefreshing sleep
   - ☐ Mood disorder
   - ☐ Insomnia
   - ☐ Congestive heart failure
   - ☐ Cognitive dysfunction
   - ☐ Atrial fibrillation
   - ☐ Fatigue
   - ☐ Type 2 diabetes mellitus
   - ☐ Daytime sleepiness
   - ☐ Hypertension
   - ☐ Stroke
   - ☐ Unintentional sleep episodes during wakefulness
   - ☐ Waking up holding breath, gasping, or choking
   - ☐ Bed partner describes loud snoring, breathing interruptions or both

NARCOLEPSY

If the requested medication is being used to treat **narcolepsy**, please answer the following:

1. Please provide baseline data of the following:

   Excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS): _____

   Excessive daytime sleepiness (EDS) via the Maintenance of Wakefulness Test (MWT): _____

2. Please provide the following results of the member's multiple sleep latency test (MSLT):

   Mean sleep latency (in minutes): _____

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____

3. Please provide the following from the member's diagnostic polysomnography:

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____

4. If the member has hypocretin-1 deficiency, please provide the following:

   Cerebrospinal fluid hypocretin-1 level (in pg/mL): _____

   Cerebrospinal fluid hypocretin-1 laboratory reference range: _____

5. Does the member have a diagnosis of cataplexy?	Yes	No

Reauthorization:

1. Is the member currently on therapy with the requested medication?	Yes	No

1a. If **YES**, please select all that apply:

☐ The member has experienced improvement in daytime sleepiness

☐ The member has experienced improvement on the ESS** or MWT*** compared to baseline

**Epworth Sleepiness Scale
***Maintenance of Wakefulness Test

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222

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