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<br>☐ Sunosi 150mg tablet | | ☐ 30 days<br>☐ 90 days<br>☐ 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 (e.g., dextroamphetamine, methylphenidate)? | Yes | No |
| 4. Please provide any other medications that the member has tried and failed:<br><br>_____<br><br>_____ | | |

**Obstructive Sleep Apnea (If the member has obstructive sleep apnea, please answer the following):**

| | | |
|---|---|---|
| 1. Is the member currently receiving and compliant with continuous positive airway pressure (CPAP)? | Yes | No |
| 2. Is the member experiencing persistent daytime sleepiness despite adequate obstructive sleep apnea treatment? | Yes | No |
| 3. Have alternative causes of daytime sleepiness been excluded? | Yes | No |
| 4. Please provide the following from the member's **diagnostic** polysomnography:<br>Apnea/hypopnea index (AHI) in events/hour: _____ | | |
| 5. Is the member experiencing any of the following symptoms? Please select **ALL** that apply:<br>☐ Coronary artery disease ☐ Unrefreshing sleep ☐ Mood disorder ☐ Insomnia<br>☐ Congestive heart failure ☐ Cognitive dysfunction ☐ Atrial fibrillation ☐ Fatigue<br>☐ Type 2 diabetes mellitus ☐ Daytime sleepiness ☐ Hypertension ☐ Stroke<br>☐ Unintentional sleep episodes during wakefulness ☐ Waking up holding breath, gasping, or choking<br>☐ Bed partner describes loud snoring, breathing interruptions or both | | |

**Narcolepsy (If the member has narcolepsy, please answer the following):**

| | | |
|---|---|---|
| 1. Please provide baseline data of the following:<br>Excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS): _____<br>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):<br>Mean sleep latency (in minutes): _____<br>Number of sleep-onset rapid eye movement periods (SOREMPs): _____ | | |
| 3. Please provide the following from the member's diagnostic polysomnography:<br>Number of sleep-onset rapid eye movement periods (SOREMPs): _____ | | |
| 4. If the member has hypocretin-1 deficiency, please provide the following:<br>Cerebrospinal fluid hypocretin-1 level (in pg/mL): _____<br>Cerebrospinal fluid hypocretin-1 laboratory reference range: _____ | | |
| 5. Does the member have a diagnosis of cataplexy? | Yes | No |

**Reauthorization:**

| 1. Is this a request for reauthorization? | 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, MC PAPHM-043B, Pittsburgh, PA 15222**