Sunosi (solriamfetol)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Excessive Daytime Sleepiness associated with Narcolepsy ☐ Obstructive Sleep Apnea (OSA) ☐ Other diagnosis: _____ICD-10:_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is patient using medication as part of a clinical trial? ☐ Yes ☐ No

Has the patient had a trial with armodafinil(Nuvigil) OR modafinil(Provigil)? ☐ Yes ☐ No *Please submit documentation.*

Is the patient's BMI within the range of 18 to less than 45 kg/m^2? ☐ Yes ☐ No

Does the patient engage in night-time shift work or variable shift work? ☐ Yes ☐ No

Is the patient's usual nightly sleep time at least 6 hours? ☐ Yes ☐ No

<u>For diagnosis of excessive daytime sleepiness associated with narcolepsy, please also answer the following</u>:
Does the patient exhibit cataplexy? ☐ Yes ☐ No *Please submit documentation.*

Does a nocturnal sleep study report document REM sleep latency less than or equal to 15 minutes?
☐ Yes ☐ No *Please submit documentation*

Does a multiple sleep latency test (MSLT) document a mean sleep latency less than or equal to 8 minutes <u>AND</u> 2 or more sleep-onset REM periods? ☐ Yes ☐ No *Please submit documentation*

<u>For diagnosis of obstructive sleep apnea, also answer the following</u>:
Does the patient have a sleep study report documenting five or more obstructive respiratory events per hour?
☐ Yes ☐ No *Please submit documentation from the sleep lab.*

Does patient have a baseline sleep latency less than 30 minutes on a 40-minute maintenance of wakefulness test?
☐ Yes ☐ No *Please submit documentation from the sleep lab.*

Is the patient currently using, or has previously failed, any of the following: CPAP, oral appliance or surgical intervention? ☐ Yes ☐ No *Please submit documentation*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811