UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Wakefulness Promoting Agents

Sunosi (solriamfetol), Wakix (pitolisant)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: Circle the diagnosis and medication

Diagnosis, Dose and Age Limitations	**Sunosi (solriamfetol)** *18 yrs. or older*	**Wakix (pitolisant)** *18 yrs. or older (narcolepsy with cataplexy)* *6 yrs. and older (narcolepsy)*
Daytime somnolence due to obstructive sleep apnea	150mg/day	
Daytime somnolence due to narcolepsy	150mg/day	35.6mg/day*
Cataplexy associated with narcolepsy		35.6mg/day*

*Specify requested dosing below.

Additional criteria for daytime somnolence due to obstructive sleep apnea:

1. Does the patient use a CPAP, or has the prescriber submitted appropriate clinical rationale for not using a CPAP? ❑ **Yes** ❑ **No**
   Rationale: _____

Criteria for Sunosi and Wakix: Step therapy required

2. Are medications for narcolepsy being prescribed by or in consultation with a provider specializing in neurology, endocrinology or sleep medicine? ❑ **Yes** ❑ **No**
3. Has the patient had an insufficient response to modafinil and/or armodafinil **OR** preferred ADHD stimulants at an adequate dose and appropriate length of treatment? (concomitant use is allowed) ❑ **Yes** ❑ **No**
   Medication and Dose: _____ Details of Failure: _____
4. For a diagnosis of narcolepsy, has the patient had an insufficient response to a sodium oxybate product at an adequate dose and appropriate length of treatment? ❑ **Yes** ❑ **No**
   Dates of Therapy: _____ Details of Failure: _____

5. Please indicate the planned titration schedule for Wakix:

Week 1	□ 8.9mg (Two 4.45mg tablets) □ Other:
Week 2	□ 17.8mg (One 17.8mg tablet) □ Other:
Week 3	□ 17.8mg (One 17.8mg tablet) □ 35.6mg (Two 17.8mg tablets) □ Other:

Off Label or Compendia Use of FDA-Approved Drugs Criteria for Approval:

1. Does the provider attest that the requested drug is being used for a medically accepted indication that is supported by information from the appropriate *compendia** of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? ❑ **Yes** ❑ **No**

   * Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines.

Reauthorization Criteria:

1. Has the provider submitted an updated letter of medical necessity or updated chart notes demonstrating a positive clinical response? ❑ **Yes** ❑ **No**
2. For daytime somnolence due to obstructive sleep apnea, will the patient continue on CPAP? ❑ **Yes** ❑ **No**
   a. Explanation for discontinuation: _____

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date