AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Sunosi

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy : Initial Authorization: ___up to 30 days ___60 days ___90 days
Reauthorization: ___up to 30 days ___60 days ___90 days ___120 days ___180 days

Clinical Information

1. Is the beneficiary age 18 or older? Yes___ No___
2. Does the beneficiary have an adequate documented trial and failure of, or contraindication to, at least one preferred drug in the Anti-Narcolepsy class on the NC PDL?
Yes___ No___ Please explain if contraindicated: _____
3. Does the beneficiary have a diagnosis of obstructive sleep apnea (OSA)? Yes___ No___
4. Does the beneficiary have a diagnosis of narcolepsy? Yes___ No___
5. Does the beneficiary have end stage renal disease (estimated glomerular filtration rate [eGFR] < 15ml/min/1.73m2)?
Yes___ No___
6. Has the beneficiary had blood pressure assessed and hypertension controlled (<= 140/90 mmHg) prior to initiating treatment?
Yes___ No___
7. Has the beneficiary received an MAO inhibitor within the previous 14 days? Yes___ No___
8. Is the beneficiary receiving concomitant noradrenergic medications? Yes___ No___
9. If using to treat OSA, does the provider attest that the beneficiary is compliant with and will continue using positive airway pressure (PAP)? Yes___ No___
10. If using to treat OSA, has the prescriber excluded any other identifiable causes for beneficiary's sleepiness (e.g. non-compliance with PAP, improperly fitted AP mask, insufficient sleep, poor sleep hygiene, depression, and/or other sleep disorders)? Yes___ No___

For continuation of therapy, please answer questions 1-13

12. Has the beneficiary developed increased blood pressure or heart rate that was not controlled by dose reduction of solriamfetol (Sunosi) or medical intervention? Yes___ No___
13. Has the beneficiary reported a documented reduction in excessive daytime sleepiness from pre-treatment baseline as measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406