

## Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

### Sunosi® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<p><b>Select the diagnosis below:</b></p> <input type="checkbox"/> Narcolepsy (confirmed by sleep study or sleep study is not feasible) <input type="checkbox"/> Obstructive Sleep Apnea (OSA) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<p><b>Clinical Information for Narcolepsy Diagnosis</b></p> <input type="checkbox"/> The recipient has tried and failed or has a contraindication to both modafinil or armodafinil. <input type="checkbox"/> If the request is for <b>continuation of therapy</b> , has the recipient experienced a documented positive clinical response to Sunosi® therapy? (Attach supporting documentation to request) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
<p><b>Clinical Information for Obstructive Sleep Apnea</b></p> <input type="checkbox"/> The recipient is unable to undergo a sleep study. <input type="checkbox"/> The recipient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study. <input type="checkbox"/> The recipient has had five or more obstructive respiratory events per hour of sleep confirmed by a sleep study. <input type="checkbox"/> One of the following signs or symptoms are present: <ul style="list-style-type: none"> <li><input type="checkbox"/> Daytime sleepiness</li> <li><input type="checkbox"/> Nonrestorative sleep</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Insomnia</li> <li><input type="checkbox"/> Waking up with breath holding, gasping, or choking</li> <li><input type="checkbox"/> Habitual snoring noted by a bed partner or other observer</li> <li><input type="checkbox"/> Observed apnea</li> </ul> <input type="checkbox"/> The recipient has used a standard treatment for the underlying obstruction for one month or longer (e.g., CPAP, BiPAP). <input type="checkbox"/> The recipient is fully compliant with ongoing treatments for underlying airway obstruction. <input type="checkbox"/> The recipient has tried and failed or has a contraindication to both modafinil or armodafinil. <input type="checkbox"/> If the request is for <b>continuation of therapy</b> , has the recipient experienced a documented positive clinical response to Sunosi® therapy and has the recipient continued to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP)? (Attach supporting documentation to request) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					

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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Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-855-455-3303.

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