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 (required)			Provider Information (required)		
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 (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Narcolepsy (confirmed by sleep study or sleep study is not feasible)
- ❑ Obstructive Sleep Apnea (OSA)
- ❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information for Narcolepsy Diagnosis

- ❑ The recipient has tried and failed or has a contraindication to both modafinil or armodafinil.
- ❑ If the request is for **continuation of therapy**, has the recipient experienced a documented positive clinical response to Sunosi® therapy? (Attach supporting documentation to request) ❑ **Yes** ❑ **No** ❑ **N/A**

Clinical Information for Obstructive Sleep Apnea

- ❑ The recipient is unable to undergo a sleep study.
- ❑ The recipient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study.
- ❑ The recipient has had five or more obstructive respiratory events per hour of sleep confirmed by a sleep study.
- ❑ One of the following signs or symptoms are present:
  - ❑ Daytime sleepiness
  - ❑ Nonrestorative sleep
  - ❑ Fatigue
  - ❑ Insomnia
  - ❑ Waking up with breath holding, gasping, or choking
  - ❑ Habitual snoring noted by a bed partner or other observer
  - ❑ Observed apnea
- ❑ The recipient has used a standard treatment for the underlying obstruction for one month or longer (e.g., CPAP, BiPAP).
- ❑ The recipient is fully compliant with ongoing treatments for underlying airway obstruction.
- ❑ The recipient has tried and failed or has a contraindication to both modafinil or armodafinil.
- ❑ If the request is for **continuation of therapy**, 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) ❑ **Yes** ❑ **No** ❑ **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?

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.