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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

NARCOLEPSY MEDICATIONS

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Minimum age of 18 for the following medications:

- ☐ Armodafinil tablet (generic for Nuvigil®) 50 mg, 150 mg, 200 mg, 250 mg (QD)
- ☐ Modafinil (generic for Provigil®) 100 mg, 200 mg (QD or BID)
- ☐ Nuvigil® 50 mg, 150 mg, 200 mg, 250 mg (QD)
- ☐ Provigil® 100 mg, 200 mg (QD or BID)
- ☐ Sunosi™ (solriamfetol) 75 mg, 150 mg
- ☐ Wakix® (pitolisant) 4.45 mg, 17.8 mg

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

Please select diagnosis from the following:

- ☐ Narcolepsy *(sleep study must be attached)*
- ☐ Excessive daytime sleepiness (EDS) in adult members with narcolepsy
- ☐ Obstructive sleep apnea *(sleep study must be attached)*
- ☐ Sudden onset of weak or paralyzed muscles (cataplexy)
- ☐ Shift work sleep disorder:
  - ☐ Current shift schedule: _____
  - ☐ Does not occur during the course of another sleep disorder or mental disorder
  - ☐ Is not due to the direct physiological effects of a medication or a general medical condition
  - ☐ Other: _____

List pharmaceutical agents attempted and outcome: _____

Medical Necessity (Provide clinical evidence that the preferred agent(s) will not provide adequate benefit or provide clinical rationale for quantity exception requests):

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Non-Preferred Medications

For Wakix® (pitolisant):

1. Does the member have an International Classification of Sleep Disorders (ICSD-3) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis of narcolepsy? **AND**

   ☐ Yes ☐ No

2. Does the member have a baseline daytime sleepiness 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)? **AND**

   ☐ Yes ☐ No

3. A mean sleep latency of ≤ 8 minutes AND ≥ 2 sleep onset REM periods (SOREMPs) are found on a mean sleep latency test (MSLT) performed according to standard techniques (A SOREMP [within 15 minutes of sleep onset] on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT); **AND**

   ☐ Yes ☐ No

4. Either cerebrospinal fluid (CSF) hypocretin-1 concentration has not been measured OR CSF hypocretin-1 concentration measured by immunoreactivity is either > 110 pg/mL OR > 1/3 of mean values obtained in normal subjects with the same standardized assay; **AND**

   ☐ Yes ☐ No

5. The hypersomnolence and/or MSLT findings are not better explained by other causes such as insufficient sleep, obstructive sleep apnea, delayed sleep phase disorder, or the effect of medication or substances or their withdrawal; **AND**

   ☐ Yes ☐ No

6. Patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for ≥ 3 months; **AND**

   ☐ Yes ☐ No

7. Patient must not be receiving treatment with sedative hypnotic agents (e.g., zolpidem, eszopiclone, zaleplon, benzodiazepines, barbiturates); **AND**

   ☐ Yes ☐ No

8. Patient will not use drugs that prolong the QT interval (e.g., quinidine, procainamide, disopyramide, amiodarone, sotalol, ziprasidone, chlorpromazine, thioridazine, moxifloxacin) concomitantly; **AND**

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

9. Patient will not use histamine-1 (H1) receptor antagonists (e.g., pheniramine maleate, diphenhydramine, promethazine, imipramine, clomipramine, mirtazapine) concomitantly; **AND**

☐ Yes ☐ No

10. Patient does not have a history of prolonged QTc interval (e.g., QTc interval > 450 milliseconds); **AND**

☐ Yes ☐ No

11. Therapy will not be used in patients with severe hepatic impairment (Child-Pugh C); **AND**

☐ Yes ☐ No

12. Patient does not have end stage renal disease (ESRD) (e.g., eGFR < 15 mL/minute/1.73 m^2).

☐ Yes ☐ No

For brand Nuvigil or Provigil:

1. Has the member tried and failed the preferred generics for the requested products?

☐ Yes ☐ No

For Renewal:

1. Does the member continue to meet initial criteria? **AND**

☐ Yes ☐ No

2. Does the member report a reduction in excessive daytime sleepiness from pre-treatment baseline? **AND**

☐ Yes ☐ No

3. Has the member not experienced andy treatment related adverse effects?

☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811