Prior Authorization Form
Narcolepsy Agents

Division of TennCare

Optum Rx®

Access this PA form at: Forms | OptumRx

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information (REQUIRED)			Prescriber Information (REQUIRED)	
Member Name:			Provider Name:	
OptumRx ID # or SSN:			NPI #:	DEA #:
Date of Birth:				Specialty:
Street Address:			Office Phone:	Office Fax:
City:	State:	Zip:	Supervising Physician and DEA # (if applicable):	
Phone:			Office Street Address:	
			City:	State: Zip:

Requested Preferred Agents: PA REQUIRED

- ☐ modafinil QL
- ☐ PROVIGIL® QL*
- ☐ XYREM QL

Is the prescriber a single-patient contract holder for this patient? ☐ Yes ☐ No

Is the prescriber a TennCare provider with a Medicaid ID? ☐ Yes ☐ No

Requested Non-Preferred Agents: PA REQUIRED

- ☐ armodafinil QL
- ☐ NUVIGIL® QL
- ☐ sodium oxybate solution QL
- ☐ SUNOSI QL
- ☐ WAKIX QL
- ☐ XYWAV QL
- ☐ Other (specify)_____

Rx information:

Strength: _____ Directions: _____ Qty: _____Duration: _____

Clinical Criteria Documentation

1. Has hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medications/substances been ruled out? ☐ Yes ☐ No

COMPLETE THE SECTION BELOW CORRESPONDING TO THE REQUESTED AGENT

Complete this section for requests for modafinil, PROVIGIL®, armodafinil, and NUVIGIL®

2. Diagnosis:
   - ☐ ADD/ADHD
   - ☐ Excessive daytime sleepiness/hypersomnolence occurring for at least 3 months associated with the following (choose below):
     - ☐ Idiopathic hypersomnia
     - ☐ Obstructive sleep apnea/hypopnea syndrome
     - ☐ Shift work sleep disorder
     - ☐ Narcolepsy
   - ☐ Other (specify): _____

3. For requests for armodafinil or NUVIGIL: has the patient tried and failed or had a contraindication or intolerance to modafinil or PROVIGIL®? ☐ Yes ☐ No
   If yes, please explain: _____

*Complete this section only if diagnosis is **ADD/ADHD***

4. Does the patient have a contraindication, adverse reaction, or drug-drug interaction to ALL preferred Anti-hyperkinesis agents (stimulants)? Current list of preferred agents can be found at TennCare Preferred Drug List (PDL) (optumrx.com) ☐ Yes ☐ No

*Complete this section only if diagnosis is **Obstructive Sleep Apnea/Hypopnea Syndrome***

Prescriber must submit documentation to support answers to the following

5. Has the patient had a sleep study? ☐ Yes ☐ No
   a. If yes, what was the date of the study? _____
6. Has the patient tried and failed use of a CPAP or BiPAP device for at least 3 months with documented compliance? ☐ Yes ☐ No
7. Does the patient have a contraindication to using a CPAP or BiPAP device? ☐ Yes ☐ No

*Complete this section only if diagnosis is **Shift Work Sleep Disorder***
Prescriber must submit documentation to support answers to the following

8. Does the prescriber have a statement of the patient's work schedule showing a minimum of 6 hours of work between the hours of 10 pm and 8 am? ☐ Yes ☐ No

Complete this section for requests for XYREM® or sodium oxybate solution

9. Is the patient enrolled in the XYREM® REMS Program (866-997-3688)? ☐ Yes ☐ No

10. Diagnosis:
- ☐ Cataplexy associated with narcolepsy
- ☐ Excessive daytime sleepiness/hypersomnolence associated with narcolepsy occurring at least 3 months
- ☐ Other _____

11. Has the patient tried and failed or had a contraindication or intolerance to modafinil or PROVIGIL®? ☐ Yes ☐ No
If yes, please explain: _____

12. For requests for sodium oxybate solution: is there a clinically valid reason why the patient requires the generic over brand XYREM? ☐ Yes ☐ No
If yes, please explain: _____

Complete this section for requests for SUNOSI®

13. Diagnosis: ☐ Excessive daytime sleepiness/hypersomnolence occurring for at least 3 months associated with the following (choose below):
- ☐ Obstructive sleep apnea/hypopnea syndrome
- ☐ Narcolepsy
- ☐ Other (specify): _____

14. Has the patient tried and failed or had a contraindication or intolerance to modafinil or PROVIGIL®? ☐ Yes ☐ No
If yes, please explain: _____

*Complete this section only if diagnosis is **Obstructive Sleep Apnea/Hypopnea Syndrome***
Prescriber must submit documentation to support answers to the following

15. Has the patient had a sleep study? ☐ Yes ☐ No
If yes, what was the date of the study? _____

16. Has the patient tried and failed use of a CPAP or BiPAP device for at least 3 months with documented compliance? ☐ Yes ☐ No

17. Does the patient have a contraindication to using a CPAP or BiPAP device? ☐ Yes ☐ No

Complete this section for requests for WAKIX®

18. Diagnosis: ☐ Excessive daytime sleepiness/hypersomnolence occurring for at least 3 months associated with the following (choose below):
- ☐ Diagnosis of cataplexy associated with narcolepsy
- ☐ Diagnosis of excessive daytime sleepiness (EDS) associated with Narcolepsy
- ☐ Other (specify): _____

19. Has the patient tried and failed or had a contraindication or intolerance to modafinil or PROVIGIL®? ☐ Yes ☐ No
If yes, please explain: _____

20. Has the patient tried and failed or had a contraindication or intolerance to XYREM®? ☐ Yes ☐ No
If yes, please explain: _____

Complete this section for requests for XYWAV®

21. Is the patient enrolled in the XYWAV® REMS Program (866-997-3688)? ☐ Yes ☐ No

22. Diagnosis:
- ☐ Cataplexy associated with narcolepsy
- ☐ Excessive daytime sleepiness/hypersomnolence associated with narcolepsy occurring for at least 3 months
- ☐ Idiopathic hypersomnia (IH) [skip to question 24]

23. Is there a clinically valid reason why the patient requires XYWAV® instead of XYREM®? ☐ Yes ☐ No
If yes, please explain: _____

24. Has the patient tried and failed or had a contraindication or intolerance to modafinil or PROVIGIL®? ☐ Yes ☐ No
If yes, please explain: _____

Continued on next page.

FOR ALL REQUESTS COMPLETE THE FOLLOWING:
25. Please include any other information pertinent to the PA request: _____
26. For requests where documentation is required, I understand that if documentation is not submitted with this form, request for prior authorization can be delayed or denied for missing information. ☐ Yes ☐ No
Prescriber Signature (Required) _____ **Date** _____ ***By signature, the prescriber confirms the above information is accurate and verifiable by patient records.***

Fax this form to 1-866-434-5523
Phone: 1-866-434-5524
OptumRx will provide a response within 24 hours upon receipt.

For additional information please visit: https://www.optumrx.com/oe_tenncare/landing.