

Prior Authorization Form Narcolepsy Agents



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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 #:					
			141111.						
Date of Birth:				Specialty:					
Street Address:			Office Phone:	Office Fax:					
City:	State:	Zip:	Supervising Physician and DEA # (if	applicable):					
Phone:			Office Street Address:						
Requested Preferred Agents: PA REQUIRED			City:	State:	Zip:				
modafinil ^{QL}			Is the prescriber a single-patient	contract hold	er for Yes No				
PROVIGIL® QL*			this patient?						
XYREM ^{QL}			Is the prescriber a TennCare pro	vider with a M	ledicaid Yes No				
			ID?						
	Req	uested Non-Pre	ferred Agents: PA REQUIRED						
armodafinil ^{QL}			☐ WAKIX ^{QL}						
□ NUVIGIL® QL			XYWAV QL						
sodium oxybate solution QL			Other (specify)						
SUNOSI QL									
Rx information:									
Strength: Directions	S:			Qty:	_Duration:				
			teria Documentation						
1. Has hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medications/substances been ruled out?									
·		CTION BELOW C	ORRESPONDING TO THE REQUES	STED AGENT					
Complete	this section fo	or requests for i	modafinil, PROVIGIL®, armodafin	il, and NUVIGI	L®				
2. Diagnosis: ADD/ADHD									
 -	Excessive daytime sleepiness/hypersomnolence occurring for at least 3 months associated with the following (choose								
below):									
□ 1-1:			nce occurring for <u>at least</u> 3 mont	hs associated v	vith the following (choose				
	athic hypersor	mnia	-	hs associated v	vith the following (choose				
Obstr	athic hypersor uctive sleep a	nnia pnea/hypopnea	-	hs associated v	vith the following (choose				
Obstr	athic hypersor	nnia pnea/hypopnea	-	hs associated v	vith the following (choose				
Obstr	athic hypersor uctive sleep a work sleep dis slepsy	nnia pnea/hypopnea	-	hs associated v	vith the following (choose				
Obstr Shift Narco Other (specify) For requests for armodafinil or N	athic hypersor uctive sleep a work sleep dis blepsy :	mnia pnea/hypopnea order	-						
Obstr Shift v Narco Other (specify) 3. For requests for armodafinil or N modafinil or PROVIGIL®?	athic hypersor uctive sleep a work sleep dis blepsy :	mnia pnea/hypopnea order	a syndrome						
Obstr Shift Narco Other (specify) For requests for armodafinil or N	athic hypersor uctive sleep a work sleep dis blepsy : IUVIGIL: has tl	mnia pnea/hypopnea corder he patient tried	a syndrome and failed or had a contraindicati						
Obstr Shift of Shift	athic hypersor uctive sleep a work sleep dis plepsy : ! !UVIGIL: has th	mnia pnea/hypopnea order he patient tried	a syndrome and failed or had a contraindication only if diagnosis is ADD/ADHD	ion or intolerai	nce to Yes No				
Obstr Shift of Shift	athic hypersor uctive sleep a work sleep dis olepsy : : !UVIGIL: has the Comp dication, adve	mnia pnea/hypopnea corder he patient tried plete this section erse reaction, or	and failed or had a contraindication only if diagnosis is ADD/ADHD or drug-drug interaction to ALL pre	ion or intolerai	nce to Yes No				
Obstr Shift v Narco Other (specify) 3. For requests for armodafinil or N modafinil or PROVIGIL®? If yes, please explain: 4. Does the patient have a contrain agents (stimulants)? Current list	athic hypersor uctive sleep a work sleep displepsy: UVIGIL: has the Comp dication, advent	mnia pnea/hypopnea corder he patient tried lete this section erse reaction, or	a syndrome and failed or had a contraindication only if diagnosis is ADD/ADHD	ion or intolerar ferred Anti-hyl List (PDL) (optu	perkinesis Yes No				
Obstr Shift of Shift	athic hypersor uctive sleep a work sleep displepsy: IUVIGIL: has the compart of preferred a te this section rescriber must	mnia pnea/hypopnea corder he patient tried elete this section erse reaction, or agents can be fo only if diagnosi.	a syndrome and failed or had a contraindication only if diagnosis is ADD/ADHD drug-drug interaction to ALL preund at TennCare Preferred Drug	ion or intolerar ferred Anti-hyl List (PDL) (optu	perkinesis Yes No				
Obstr Shift v Narco Other (specify) 3. For requests for armodafinil or N modafinil or PROVIGIL®? If yes, please explain: 4. Does the patient have a contrain agents (stimulants)? Current list Complete *Pr 5. Has the patient had a sleep study	athic hypersor uctive sleep a work sleep displepsy: IUVIGIL: has the computation, adverse of preferred a te this section rescriber mustry?	mnia pnea/hypopnea corder he patient tried elete this section erse reaction, or agents can be fo only if diagnosi.	and failed or had a contraindication only if diagnosis is ADD/ADHD reduced required at TennCare Preferred Drug is is Obstructive Sleep Apnea/Hyp	ion or intolerar ferred Anti-hyl List (PDL) (optu	perkinesis Yes No				
Obstr Shift v Narcc Other (specify) 3. For requests for armodafinil or N modafinil or PROVIGIL®? If yes, please explain: 4. Does the patient have a contrain agents (stimulants)? Current list Complete *Pr 5. Has the patient had a sleep study a. If yes, what was the date of	athic hypersor uctive sleep a work sleep displepsy: IUVIGIL: has the computation, adverse of preferred a te this section rescriber must y? the study?	mnia pnea/hypopnea corder he patient tried elete this section erse reaction, or agents can be fo only if diagnosic submit docume	a syndrome and failed or had a contraindication only if diagnosis is ADD/ADHD r drug-drug interaction to ALL preund at TennCare Preferred Drug is is Obstructive Sleep Apnea/Hypentation to support answers to the	ferred Anti-hy List (PDL) (optu popnea Syndro ne following*	perkinesis Yes No www.com) www.com) Wes No				
Obstr Shift v Narcc Other (specify) 3. For requests for armodafinil or N modafinil or PROVIGIL®? If yes, please explain: 4. Does the patient have a contrain agents (stimulants)? Current list Complete *Pr 5. Has the patient had a sleep study a. If yes, what was the date of	athic hypersor uctive sleep a work sleep displepsy: IUVIGIL: has the computation, adverse of preferred a te this section rescriber must by? the study?	mnia pnea/hypopnea corder he patient tried elete this section erse reaction, or egents can be for only if diagnosis submit docume	and failed or had a contraindication only if diagnosis is ADD/ADHD of drug-drug interaction to ALL presund at TennCare Preferred Drug is is Obstructive Sleep Apnea/Hypentation to support answers to the	ferred Anti-hy List (PDL) (optu popnea Syndro ne following*	perkinesis Yes No www.com) www.com) Wes No				

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	Complete this section only if diagnosis is Shift Work Sleep Disorder *Prescriber must submit desumentation to support answers to the following*	
8.	*Prescriber must submit documentation to support answers to the following* Does the prescriber have a statement of the patient's work schedule showing a minimum of 6 hours of work between	Yes No
0.	the hours of 10 pm and 8 am?	
	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	B. Diagnosis: Excessive daytime sleepiness/hypersomnolence occurring for at least 3 months associated with the following state of the s	wing (choose
-5	below):	wing (choose
	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	
4.5	*Prescriber must submit documentation to support answers to the following*	
15.	Has the patient had a sleep study?	☐ Yes ☐No
16	If yes, what was the date of the study? Has the patient tried and failed use of a CPAP or BiPAP device for at least 3 months with documented compliance?	☐ Yes ☐ No
	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 follow	wing (choose
	below):	0 (
	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
20	If yes, please explain:	Dyss DNs
20.	Has the patient tried and failed or had a contraindication or intolerance to XYREM®? If yes, please explain:	∐ Yes ∐No
	Complete this section for requests for XYWAV®	
21.	Is the patient enrolled in the XYWAV® REMS Program (866-997-3688)?	Yes No
	Diagnosis: Cataplexy associated with narcolepsy	
	Excessive daytime sleepiness/hypersomnolence associated with narcolepsy occurring for at least 3 month	าร
	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:	
	Continuer	on next page.
	Continued	on next page.

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FOR ALL REQUESTS COMPLETE THE FOLLOWING:					
25. Please inc	clude any other information pertinent to the PA request:				
•	ests where documentation is required, I understand that if documentation is not submitted with this form, or prior authorization can be delayed or denied for missing information.	Yes No			
By sig	Prescriber Signature (Required) gnature, the prescriber confirms the above information is accurate and verifiable by patient records.	ate			

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.