Prior Authorization Request Form for
solriamfetol **(Sunosi)**

# USFHP Pharmacy Prior Authorization Form

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and Applicable Progress Notes to: (410) 424-4037**

| To be completed by Requesting provider | |
|---|---|
| Drug Name: | Strength: |
| Dosage/Frequency (SIG): | Duration of Therapy: |

***Questions?*** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.
Prior Authorization expires after 1 year.

**Step 1** **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

**Step 2** **Please complete the clinical assessment:**

| | | |
|---|---|---|
| 1. **Does the provider acknowledge that a prior authorization is not required for modafinil or armodafinil?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| 2. **Is the patient a child, adolescent, or pregnant patient?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **3** |
| 3. **Is the patient greater than or equal to 18 years of age?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| 4. **Does the patient have a documented diagnosis of excessive daytime sleepiness associated with narcolepsy?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>Proceed to question **5** |
| 5. **Does the patient have a documented diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA)?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| 6. **Does the patient have an Epworth Sleepiness Scale (ESS) score greater than or equal 10?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| 7. **Has the patient's underlying airway obstruction been treated with continuous positive airway pressure (CPAP) for at least 1 month prior to initiation, and the patient demonstrated adherence to therapy during this time?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| 8. **Will the patient continue treatment for underlying airway obstruction (CPAP or similar) throughout duration of treatment?** | ☐ Yes<br>Proceed to question **11** | ☐ No<br>**STOP**<br>**Coverage not approved** |

| | | |
|---|---|---|
| **9. Has narcolepsy been diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **10. Have other causes of sleepiness been ruled out or treated (including but not limited to obstructive sleep apnea if the patient has narcolepsy)?** | ☐ Yes<br>Proceed to question **11** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **11. Is the requested medication being prescribed by or in consultation with a neurologist, psychiatrist, or sleep medicine specialist?** | ☐ Yes<br>Proceed to question **12** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **12. Will there be concurrent use with a central nervous system depressant, such as a narcotic analgesic (including tramadol), a benzodiazepine, or a sedative hypnotic?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **13** |
| **13. Will the patient be using a monoamine oxidase inhibitor (MAOI) with the requested medication, or has there been MAOI use within the last 14 days?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **14** |
| **14. Will the patient be taking modafinil, armodafinil, or stimulant-based therapy, such as amphetamine or methylphenidate with the requested medication?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **15** |
| **15. Has the patient tried and failed and had an inadequate response to modafinil?** | ☐ Yes<br>Proceed to question **16** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **16. Has the patient tried and failed and had an inadequate response to armodafinil?** | ☐ Yes<br>Proceed to question **17** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **17. Has the patient tried and failed and had an inadequate response to stimulant based therapy (amphetamine or methylphenidate)?** | ☐ Yes<br>Proceed to question **18** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **18. Does the patient and provider agree to monitor blood pressure and heart rate at baseline and periodically throughout treatment?** | ☐ Yes<br>Proceed to question **19** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **19. Does the patient have hypertension?** | ☐ Yes<br>Proceed to question **20** | ☐ No<br>Proceed to question **21** |
| **20. Is the patient's blood pressure controlled?** | ☐ Yes<br>Proceed to question **21** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **21. Does the patient have unstable cardiovascular disease, serious heart arrhythmias, or other serious heart problems?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Sign and date below** |

†Non-FDA-approved uses are not approved (including but not limited to fibromyalgia, insomnia, excessive sleepiness not associated with narcolepsy, major depression, ADHD, or shift work disorder).

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**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[27 October 2020]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |
| Date Faxed to MD: | Date Decision Rendered: |