Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health

Modafinil (Provigil), Armodafinil (Nuvigil), Solriamfetol (Sunosi) and Pitolisant (Wakix) – Medical Necessity Request

Complete pages 1 and 2 for Initial Requests

General Information:

1. **For Solriamfetol (Sunosi) and Pitolisant (Wakix) requests only**: Can the prescription be changed to modafinil or armodafinil?
   - □ Yes: Please notify the pharmacy of the change and proceed to next section.
   - □ No: Please provide the clinical reason(s) why both modafinil and armodafinil cannot be tried, then proceed to next section.

   _____

Contraindication Information:

1. **For Solriamfetol (Sunosi) requests only**: Will it be used together with a Monoamine Oxidase Inhibitor (MAOI - e.g., Rasagiline, Selegiline, Phenelzine and other similar drugs) or did the member use a MAOI within the past 14 days? **Yes or No**

2. **For Pitolisant (Wakix) requests only**: Does the member have severe hepatic impairment? **Yes or No**

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Narcolepsy

□ Obstructive sleep apnea/hypopnea syndrome (OSAHS)

a. Does the member have excessive sleepiness? **Yes or No**
b. Has the diagnosis been confirmed by polysomnography or home sleep apnea testing? **Yes or No**
c. Has the member been treated for the underlying obstruction with CPAP, BiPAP, oral appliances and/or surgery? **Yes or No**
   - If yes, please specify what the member has been treated with: _____
d. Will the member continue to be treated with CPAP, BiPAP and/or oral appliances together with the requested medication? **Yes or No**
e. Have other causes of excessive sleepiness been ruled out (e.g., non-compliance with CPAP, ill-fitting CPAP masks, insufficient sleep, poor sleep hygiene, etc.)? **Yes or No**

□ Shift work sleep disorder (SWSD)

a. Does the member have excessive sleepiness? **Yes or No**
b. Has the member been symptomatic for at least 3 months? **Yes or No**
c. Does the member work at least 5 night shifts per month? **Yes or No**

Continued on p. 2

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

□ Fatigue

a. What is the fatigue associated with?

□ Multiple Sclerosis

□ Depression (Please answer the questions listed under the diagnosis of Depression, p. 2)

□ Other: _____

□ Multiple Sclerosis

a. Does the member have associated fatigue? **Yes or No**

□ Attention deficit hyperactivity disorder (ADHD)/ Attention deficit disorder (ADD)

a. Can the member try a formulary ADHD medication? **Yes or No**

NOTE: Formulary medications include: dexmethylphenidate immediate-release/extended-release preparation, methylphenidate immediate-release/extended-release preparation, mixed-salts amphetamine immediate-release/extended-release preparation, atomoxetine, guanfacine immediate-release/extended-release preparation, clonidine.

- If yes, please call the formulary ADHD medication prescription into the member's pharmacy.
- If no, please provide the clinical reason why a formulary medication cannot be tried?

_____

b. What medication(s) has the member tried for ADHD/ADD, and the reason(s) each was discontinued (stopped)?

_____

□ Depression

a. Does the member have Major Depressive Disorder? **Yes or No**
b. Does the member have associated fatigue? **Yes or No**
c. Has the member tried and failed at least two antidepressant therapies (i.e. Fluoxetine, Paroxetine, Venlafaxine Duloxetine, Bupropion)? **Yes or No**
   - If No, can the member try an antidepressant therapy? **Yes or No**
     - If yes, please call the prescription into the member's pharmacy
     - If no, please provide the clinical reason why

_____

d. Which medication(s) has the member tried?

_____

e. Will the member be receiving modafinil in combination with a SSRI (selective serotonin reuptake inhibitor)? **Yes or No**

f. Does the member continue to have residual symptoms (i.e. fatigue, hypersomnolence)? **Yes or No**

□ Other: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health

Modafinil (Provigil), Armodafinil (Nuvigil), Solriamfetol (Sunosi) and Pitolisant (Wakix) – Medical Necessity Request

Complete this page for Subsequent Requests

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Narcolepsy

□ Obstructive sleep apnea/hypopnea syndrome (OSAHS)

a. Will the member continue to be treated for the underlying obstruction with CPAP, BiPAP and/or oral appliances together with the requested medication? **Yes or No**

□ Shift work sleep disorder (SWSD)

a. Does the member work at least 5 night shifts per month? **Yes or No**

□ Fatigue

a. Is the fatigue associated with Multiple Sclerosis or Depression? **Yes or No**
(For Depression, please answer the questions under depression)

□ Multiple Sclerosis

a. Does the member have associated fatigue? **Yes or No**

□ Depression

a. Does the member have Major Depressive Disorder? **Yes or No**
b. Does the member have associated fatigue? **Yes or No**
c. Will the member be receiving modafinil in combination with a SSRI (selective serotonin reuptake inhibitor)? **Yes or No**

□ Attention deficit hyperactivity disorder (ADHD)/ Attention deficit disorder (ADD)

□ Other: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**