AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

NARCOLEPSY MEDICATIONS

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA 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):

Preferred Medications

1. For Sunosi, has the member tried and failed either modafinil or armodafinil?

   ☐ Yes ☐ No

(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 PA process.
Submission of documentation does NOT guarantee coverage.