

# SUNOSI (solriamfetol)

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermyeds.com](http://covermyeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis: <input type="checkbox"/> Excessive daytime sleepiness associated with obstructive sleep apnea (OSA) <input type="checkbox"/> Excessive daytime sleepiness associated with narcolepsy <input type="checkbox"/> Other (ICD code plus description): _____
Medication Requested: _____ Strength: _____
Dosing Schedule: _____ Quantity per Month: _____
<b>For all requests:</b> 1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindication: _____ _____ 3. Is the patient’s age within FDA labeling for the requested indication for the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____ _____ 4. Has the patient been diagnosed with stage four advanced, metastatic cancer? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the requested agent being used to treat the cancer? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is the requested agent being used to treat an associated condition related to stage four advanced metastatic cancer? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to either of the above, is use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; AND approved by the United States Food and Drug Administration? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Please continue to the next page.</b>

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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5. Has the patient tried and had an inadequate response to armodafinil OR modafinil? .....  Yes  No  
 If yes, please specify agent: \_\_\_\_\_  
 If no, was armodafinil OR modafinil discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No  
 If yes, please specify agent: \_\_\_\_\_  
 If no, does the patient have an intolerance or hypersensitivity to armodafinil OR modafinil? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 \_\_\_\_\_  
 If no, does the patient have an FDA labeled contraindication to BOTH armodafinil AND modafinil? ....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
 \_\_\_\_\_

6. Are ONE of the following expected of armodafinil OR modafinil: 1) to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug, 2) cause a significant barrier to the patient's adherence of care, 3) worsen a comorbid condition, 4) decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities, OR 5) cause an adverse reaction or cause physical or mental harm? .....  Yes  No

7. Is armodafinil OR modafinil not in the best interest of the patient based on medical necessity? .....  Yes  No

8. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as armodafinil OR modafinil and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

9. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., neurologist, psychiatrist, pulmonologist, sleep disorder specialist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ...  Yes  No

10. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For Excessive daytime sleepiness associated with obstructive sleep apnea (OSA) requests:**

11. Has the underlying airway obstruction been treated (e.g., continuous positive airway pressure [CPAP]) for at least 1-month prior to initiating therapy with the requested agent? .....  Yes  No

12. Will the modalities to treat the underlying airway obstruction (e.g., continuous positive airway pressure [CPAP]) be continued during treatment with the requested agent? .....  Yes  No

**For renewal requests:**

13. Has the patient had clinical benefit with the requested agent? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121  
**TOLL FREE**  
**Phone:**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**  
**Fax: 877.243.6930**

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