

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:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

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Date of Birth:

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Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

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NPI Number:

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Phone Number:

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Fax Number:

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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:

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Member's First Name:

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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):

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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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:

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Member's First Name:

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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 m2).

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 any 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.