MOLINA HEALTHCARE

Anti Narcolepsy Agents
Armodafinil/Modafinil/Lumryz/Sunosi/Wakix/Xyren/Xywav

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.

Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082.

Apple Health Preferred Drug List: *https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx*

Date of request:			
Patient	Date of birth	Molina ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength		Directions for use	Qty/Days supply

1. Indicate the patient's diagnosis
☐ Idiopathic Hypersomnia confirmed with a sleep study and multiple sleep latency test
☐ Narcolepsy with Excessive Daytime Sleepiness confirmed with a sleep study and multiple sleep latency test
☐ Narcolepsy with Cataplexy confirmed with a sleep study and multiple sleep latency test
☐ Obstructive Sleep Apnea with Excessive Daytime Sleepiness confirmed with a sleep study
☐ Shift Work Sleep Disorder
☐ Other. Specify: ________________

2. Does patient have a history of failure as stated below, contraindication, or intolerance to any of the following (check all that apply):
☐ Amphetamine or methylphenidate-based stimulant.
Specify duration of trial (number of consecutive days): ___________________
☐ Armodafinil (Nuvigil). Specify duration of trial (number of consecutive days): ______________
☐ Modafinil (Provigil). Specify duration of trial (number of consecutive days): _______________
☐ Pitolisant (Wakix). Specify duration of trial (number of consecutive days): ________________
☐ Sodium oxybate (Xyrem). Specify duration of trial (number of consecutive days): __________
☐ Solriamfetol (Sunosi). Specify duration of trial (number of consecutive days):
☐ Other contraindication or intolerance. Specify drug and describe: _______________________

3. Is the medication prescribed by, or in consultation with, a neurologist, psychiatrist, or sleep specialist? ☐ Yes ☐ No

4. Has patient had a quantitative assessment completed within the last 6 months (e.g., Epworth Sleepiness Scale, Maintenance of Wakefulness Test)?
☐ Yes. Specifiy Score: ____________
☐ No

5. Is this request for a continuation of therapy? ☐ Yes ☐ No
If yes, does patient have clinical documentation demonstrating the following (check all that apply):

☐ Disease stability
☐ Improvement of patient's symptoms
☐ Patient still requires treatment for shift work sleep disorder
☐ Positive clinical response
☐ Reduction of cataplexy events

For diagnosis of Idiopathic Hypersomnia, answer the following:

6. Does the provider attest the cause of hypersomnia is not better explained by another medical disorder, use of substance, or medication? ☐ Yes ☐ No

For diagnosis of Narcolepsy with Cataplexy, answer the following:

7. Does patient have clinical documentation that supports any of the following (check all that apply):
☐ Presence of cataplexy (e.g., documented episodes of sudden loss of muscle tone)
☐ Impairment/limitation of activities of daily living (e.g., unable to attend school, unable to attend work, unable to drive)?

For diagnosis of Obstructive Sleep Apnea with Excessive Daytime Sleepiness, answer the following:

8. Has the patient achieved normalized breathing (< 5 apnea-hypopnea incidences/hr) and oxygenation with continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP)? ☐ Yes ☐ No

9. Does patient have documentation within the past 6 months, demonstrating adherence to any of the following (check all that apply)?
☐ CPAP or BIPAP therapy (CPAP or BIPAP is used for 70% of nights for a minimum of 4 hours per night)
☐ Mandibular advancement device
☐ Other. Specify: _________________

For diagnosis of Shift Work Sleep Disorder, answer the following:

10. Is there clinical documentation demonstrating concomitant use of nonpharmacologic interventions (i.e., counseling, sleep hygiene)? ☐ Yes ☐ No

All requests require chart notes

For diagnosis of idiopathic hypersomnia OR narcolepsy, provide the following:

- Sleep study and multiple sleep latency test (MSLT)
- Quantitative assessment within the past 6 months (e.g. Epworth Sleepiness Scale, Maintenance of Wakefulness Test)

For diagnosis of obstructive sleep apnea with excessive daytime sleepiness, provide the following:

- Sleep study
- Quantitative assessment within the past 6 months (e.g., Epworth Sleepiness Scale, Maintenance of Wakefulness Test)
- Documentation of adherence to CPAP/BIPAP therapy or mandibular advancement device compliance in the last 6 months

For continuation of therapy, provide clinical documentation demonstrating disease stability or a positive clinical response.

- For obstructive sleep apnea, documentation of adherence to CPAP/BiPAP or mandibular advancement device is required.
- For narcolepsy with cataplexy continuation of therapy requests, provide clinical documentation showing a reduction of cataplexy events.

For shift work sleep disorder:

- Documentation patient still requires treatment

Prescriber signature	Prescriber specialty	Date