

Sunosi (solriamfetol) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

			URGENT	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:		L		
CITY:		STATE: ZIP CODE:		
PATIENT INSURANCE ID NUN	MBER:	I		
MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES: F YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF				
PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):				
PRESCRIBER INFORMATION				
LAST NAME:		FIRST NAME:		
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:		
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:		
MEDICATION OR MEDICAL I	DISPENSING INFORMATION			
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY	INITIATED:	
DURATION OF THERAPY (SPE	CIFIC DATES):			

Continued on next page.



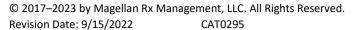


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MEMBER'S LAST NAME:	MEMBER'S FIRST	MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
□ Excessive Daytime Sleepiness associated□ Obstructive Sleep Apnea (OSA)□ Other diagnosis:				
3. REQUIRED CLINICAL INFORMATION: PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A		
Clinical Information:				
Is patient using medication as part of a	a clinical trial? Yes No			
Has the patient had a trial with armodafinil(Nuvigil) OR modafinil(Provigil)? ☐ Yes ☐ No Please submit documentation.				
Is the patient's BMI within the range of 18 to less than 45 kg/m²? □ Yes □ No				
Does the patient engage in night-time shift work or variable shift work? ☐ Yes ☐ No				
Is the patient's usual nightly sleep time at least 6 hours? ☐ Yes ☐ No				
	epiness associated with narcolepsy, plear Yes No Please submit documente			
Does a nocturnal sleep study report do ☐ Yes ☐ No Please submit document	ocument REM sleep latency less than or tation	equal to 15 minutes?		
	LT) document a mean sleep latency less S O No Please submit documentation	• —		
For diagnosis of obstructive sleep apnea, also answer the following: Does the patient have a sleep study report documenting five or more obstructive respiratory events per hour? Solve the patient have a sleep study report documenting five or more obstructive respiratory events per hour? Solve the patient have a sleep study report documenting five or more obstructive respiratory events per hour?				
Does patient have a baseline sleep late ☐ Yes ☐ No Please submit document	ency less than 30 minutes on a 40-minu tation from the sleep lab.	te maintenance of wakefulness test?		
Is the patient currently using, or has previously failed, any of the following: CPAP, oral appliance or surgical intervention? Yes No Please submit documentation				



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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:
Are there any other comments, diagnoses, s physician feels is important to this review?	ymptoms, medications tried or failed, and/or any other information the
*Please note: Not all drugs/diagnoses are co- information is received.	vered on all plans. This request may be denied unless all required
•	ded is true and accurate to the best of my knowledge. I understand that designees may perform a routine audit and request the medical of the information reported on this form.
Prescriber Signature or Electronic I.D. Verific	cation: Date:
you are not the intended recipient, you are hereby not	ring this transmission contain confidential health information that is legally privileged. If if ified that any disclosure, copying, distribution, or action taken in reliance on the contents received this information in error, please notify the sender immediately (via return FAX)

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

