



Prior Authorization Request Administrative Information

Member information

Last name First name MI

Member ID Date of birth

Sex assigned at birth Female Male "X" or Intersex

Current gender Female Male Transgender male Transgender female Other

Place of residence Home Nursing facility Other

Race Ethnicity

Preferred spoken language Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan contact information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, and Children's Medical Security Plan

MassHealth Drug Utilization Review Program

Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318

MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)

Fallon Health

Online Prior Authorization: go.covermy meds.com/OptumRx

Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum

Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033

Health New England

Online Prior Authorization: go.covermy meds.com/OptumRx

Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

Mass General Brigham Health Plan

Online Prior Authorization (Pharmacy Benefit Reviews): go.covermy meds.com/OptumRx

Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555

Online Prior Authorization (Medical Specialty Reviews): provider.massgeneralbrighamhealthplan.org

Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611

Tufts Health Plan

Online Prior Authorization: point32health.promptpa.com

Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985

WellSense Health Plan

Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations

Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

Narcolepsy and Miscellaneous Sleep Disorder Therapy Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Medication information

Medication requested

- | | | |
|---|--|--|
| <input type="checkbox"/> armodafinil > 1 unit/day | <input type="checkbox"/> sodium oxybate | <input type="checkbox"/> Xywav (calcium oxybate/
magnesium oxybate/potassium
oxybate/sodium oxybate) |
| <input type="checkbox"/> modafinil 100 mg > 1.5
unit/day | <input type="checkbox"/> Sunosi (solriamfetol) | |
| <input type="checkbox"/> modafinil 200 mg > 2 units/day | <input type="checkbox"/> tasimelteon | |
| | <input type="checkbox"/> Wakix (pitolisant) | |

Dose and frequency of medication requested

Indication (Check all that apply or include ICD-10 code, if applicable.)

- | | |
|---|---|
| <input type="checkbox"/> Cataplexy associated with narcolepsy | <input type="checkbox"/> Non-24-hour sleep-wake disorder |
| <input type="checkbox"/> Idiopathic hypersomnia | <input type="checkbox"/> Smith-Magenis Syndrome (SMS) |
| <input type="checkbox"/> Excessive daytime sleepiness (EDS)
associated with narcolepsy | <input type="checkbox"/> Other (Please specify.) <input type="text"/> |
| <input type="checkbox"/> EDS associated with obstructive sleep apnea
(OSA) | |

Please indicate prescriber specialty below.

- Neurology Sleep Other (Please specify.)

If prescriber is not a specialist, please attach consult notes from a specialist.

Section I. Please complete for sodium oxybate, Sunosi, Wakix, and Xywav for the diagnosis of narcolepsy. Please also complete Section IV or V below as appropriate.

Has the member had a sleep study (polysomnogram or multiple sleep latency test) that diagnosed narcolepsy?

- Yes. Please include medical records with submission.
- No. Please explain why this member has not had a sleep study or why treatment is required when sleep study did not document narcolepsy.

Section II. Please complete for Sunosi for the diagnosis of EDS associated with OSA.

- Has the member had a sleep study (polysomnogram) that diagnosed obstructive sleep apnea?
 Yes. Please include medical records with submission. No
- Is the member utilizing CPAP/BiPAP, an oral appliance, or has undergone successful surgical treatment for OSA?
 Yes. Please include medical records with submission.
 No. Please explain why this member is not utilizing CPAP/BiPAP, an oral appliance, or surgical treatment for OSA.

3. For Sunosi, has the member tried modafinil or armodafinil for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes In Section VII below.
 - No. Please describe clinical rationale why modafinil and armodafinil are not appropriate for this member.
-

Section III. Please complete for requests for the diagnosis of non-24-hour sleep-wake disorder and SMS.

For the diagnosis of non-24-hour sleep-wake disorder, please complete questions 1 and 2. For SMS, complete questions 1 and 3.

1. Has the member tried melatonin for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes in Section VII below.
 - No. Please describe clinical rationale why melatonin is not appropriate for this member.
-
2. Is the member totally blind? Yes No
3. For tasimelteon suspension, please provide medical necessity for use instead of the capsule formulation.
-

Section IV. Please also complete for requests for sodium oxybate, Sunosi, Wakix, and Xywav for a diagnosis of EDS associated with narcolepsy. Please complete Section I above as appropriate.

1. Has the member tried modafinil or armodafinil for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes in Section VII below.
 - No. Please describe clinical rationale why modafinil and armodafinil are not appropriate for this member.
-
2. Has the member tried a cerebral stimulant for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes in Section VII below.
 - No. Please describe clinical rationale why cerebral stimulants are not appropriate for this member.
-
3. For Sunosi, will the requested medication be used in combination with other stimulants or stimulant-like agents?
- Yes. Please describe clinical rationale for combination therapy with other stimulants or stimulant-like agents.
-
- No.
4. For Wakix, has the member tried Sunosi for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes in Section VII below.
 - No. Please describe the clinical rationale why Sunosi is not appropriate for this member.
-
5. For Wakix, has the member tried sodium oxybate for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes in Section VII below.
 - No. Please describe the clinical rationale why sodium oxybate is not appropriate for this member.
-
6. For Xywav, please describe clinical rationale why sodium oxybate is not appropriate for this member.
- Yes. Please explain.
 - No

Section V. Please also complete for requests for sodium oxybate, Wakix, and Xywav for a diagnosis of cataplexy associated with narcolepsy. Please complete Section I above as appropriate.

1. Has the member tried atomoxetine, a selective serotonin reuptake inhibitor (SSRI), tricyclic antidepressant (TCA), or venlafaxine for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes in Section VII below.
- No. Please describe clinical rationale why SSRIs, TCAs, and venlafaxine are not appropriate for this member.
2. For Wakix, has the member tried sodium oxybate or Xywav for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes in Section VII below.
- No. Please describe the clinical rationale why sodium oxybate and Xywav are not appropriate for this member.
3. For Xywav, is there clinical rationale for use instead of sodium oxybate for the treatment of this condition?*
- Yes. Please explain.
- No

Section VI. Please also complete for requests for sodium oxybate and Xywav for a diagnosis of idiopathic hypersomnia.

1. Has the member had a polysomnogram ruling out other causes of hypersomnia?
- Yes. Please include medical records with submission.
- No. Please explain why not.
2. Has the member had a multiple sleep latency test?
- Yes. Please include medical records with submission.
- No. Please explain why not.
3. Does the member have hypersomnia due to another medical, behavioral, or psychiatric disorder?
- Yes. Please explain.
- No.
4. Please attach a current medication list. Is the member currently utilizing a drug that can cause excessive daytime sleepiness?
- Yes. Please explain.
- No.
5. Has the member tried a cerebral stimulant for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes in Section VII below.
- No. Please describe clinical rationale why cerebral stimulants are not appropriate for this member.
6. Has the member tried modafinil or armodafinil for the treatment of this condition?*
- Yes. Please list the drug name, dates of trials and outcomes in Section VII below.
- No. Please describe clinical rationale why modafinil and armodafinil are not appropriate for this member.
7. For Xywav, is there clinical rationale for use instead of sodium oxybate for the treatment of this condition?*
- Yes. Please explain.
- No

Section VII. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

Drug Dates of use

Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

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Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

Drug Dates of use

Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, or other.

Section VIII. Please complete for requests for quantities above quantity limits.

Please describe medical necessity for exceeding the quantity limits.

Section IX. Please complete for requests for concomitant use of modafinil and armodafinil.

Please describe medical necessity for concomitant use of modafinil and armodafinil.

Section X. Please complete and provide documentation for exceptions to step therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to, the member? Yes No

If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?

Yes No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?

Yes No

If yes, please provide details for the previous trial.

Drug name Dates/duration of use

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response.

4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in, or physical or mental harm to, the member?

Yes. Please provide details.

No

Please continue to next page and complete Prescriber and Provider Information section.

Prior Authorization Request Prescriber and Provider Information

Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

* Required

Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
				No. of units	<input type="text"/>

Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

<input type="text"/>	Date	<input type="text"/>
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(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)