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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, Children's Medical Security Plan, and Health Safety Net 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.covermymeds.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.covermymeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
☐ **Mass General Brigham Health Plan** Online Prior Authorization (Non-Specialty Drugs): go.covermymeds.com/OptumRx Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
☐ **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

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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

- ☐ armodafinil > 1 unit/day
- ☐ modafinil 100 mg > 1.5 unit/day
- ☐ modafinil 200 mg > 2 units/day
- ☐ sodium oxybate
- ☐ Sunosi (solriamfetol)
- ☐ tasimelteon
- ☐ Wakix (pitolisant)
- ☐ Xywav (calcium oxybate/ magnesium oxybate/potassium oxybate/sodium oxybate)

Dose and frequency of medication requested

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

- ☐ Cataplexy associated with narcolepsy
- ☐ Idiopathic hypersomnia
- ☐ Excessive daytime sleepiness (EDS) associated with narcolepsy
- ☐ EDS associated with obstructive sleep apnea (OSA)
- ☐ Non-24-hour sleep-wake disorder
- ☐ Smith-Magenis Syndrome (SMS)
- ☐ Other (Please specify.)

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.

1. Has the member had a sleep study (polysomnogram) that diagnosed obstructive sleep apnea?
   ☐ Yes. Please include medical records with submission. ☐ No
2. 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

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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

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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.

_____

Drug _____ Dates of use _____

☐ 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

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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.

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Prior Authorization Request Prescriber and Provider Information

Prescriber Information

Last name* First name* MI

NPI* Individual MH Provider ID

DEA No. Office Contact Name

Address City State Zip

Email address

Telephone No.* Fax No.*

** Required*

Please also complete for professionally administered medications, if applicable.

Start date End date

Servicing prescriber/facility name ☐ Same as prescribing provider

Servicing provider/facility address

Servicing provider NPI/tax ID No.

Name of billing provider

Billing provider NPI No.

Is this a request for recertification? ☐ Yes ☐ No

CPT code No. of visits J code No. of units

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my 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.

Prescribing provider's signature _____

Printed name of prescribing provider Date

(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.)