Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

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.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ armodafinil ☐ modafinil ☐ Xyrem (sodium oxybate)
☐ Hetlioz (tasimelteon) ☐ Sunosi (solriamfetol)

Dose and frequency of medication requested _____

Indication (Check all that apply.)

☐ Cataplexy associated with narcolepsy
☐ Excessive daytime sleepiness (EDS) associated with narcolepsy
☐ EDS associated with obstructive sleep apnea (OSA)
☐ EDS associated with shift work sleep disorder
☐ Non-24-hour sleep-wake disorder
☐ 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 all requests for the diagnosis of narcolepsy. For Sunosi and Xyrem requests, 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 requests 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 VI below.
   - ☐ No. Please describe clinical rationale why modafinil or armodafinil is not appropriate for this member.

_____

Section III. Please complete for requests for the diagnosis of EDS associated with shift work sleep disorder and non-24-hour sleep-wake disorder.

For requests for a diagnosis of EDS associated with shift work sleep disorder, please complete questions 1 and 2. For requests for a diagnosis of non-24-hour sleep-wake disorder, please complete questions 2 and 3.

1. Has the member tried a hypnotic agent for the treatment of this condition?*
   - ☐ Yes. Please list the drug name, dates of trials, and outcomes in Section VI below.
   - ☐ No. Please describe clinical rationale why a hypnotic agent is not appropriate for this member.

_____

2. Has the member tried melatonin for the treatment of this condition?*
   - ☐ Yes. Please list the drug name, dates of trials and outcomes in Section VI below.
   - ☐ No. Please describe clinical rationale why melatonin is not appropriate for this member.

_____

3. Is the member totally blind? ☐ Yes ☐ No

Section IV. Please also complete for requests for Sunosi and Xyrem 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 VI below.
   - ☐ No. Please describe clinical rationale why modafinil or armodafinil is not appropriate for this member.

_____

2. Has the member tried a cerebral stimulant medication for the treatment of this condition?*
   - ☐ Yes. Please list the drug name, dates of trials and outcomes In Section VI below.
   - ☐ No. Please describe clinical rationale why modafinil or armodafinil is not appropriate for this member.

_____

3. For Sunosi, will the requested medication be used as monotherapy?
   - ☐ Yes
   - ☐ No. Please describe treatment plan including clinical rationale for combination therapy.

_____

Section V. Please also complete for requests for Xyrem for a diagnosis of cataplexy associated with narcolepsy. Please complete Section I above as appropriate.

Has the member tried 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 VI below.
- ☐ No. Please describe clinical rationale why SSRIs, TCAs, and venlafaxine are not appropriate for this member. _____

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Section VI. 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.

_____

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

Please describe the clinical rationale for exceeding the quantity limit.

_____

_____

Section VIII. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

** Please attach a letter documenting additional trials as necessary.*

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

** Required*

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 (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____