Nevada Medicaid – Molina Healthcare
Sunosi® Prior Authorization Request Form

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: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Narcolepsy (confirmed by sleep study or sleep study is not feasible)
- ❑ Obstructive Sleep Apnea (OSA)
- ❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information for Narcolepsy Diagnosis

- ❑ The recipient has tried and failed or has a contraindication to both modafinil or armodafinil.
- ❑ If the request is for **continuation of therapy**, has the recipient experienced a documented positive clinical response to Sunosi® therapy? (Attach supporting documentation to request) ❑ **Yes** ❑ **No** ❑ **N/A**

Clinical Information for Obstructive Sleep Apnea

- ❑ The recipient is unable to undergo a sleep study.
- ❑ The recipient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study.
- ❑ The recipient has had five or more obstructive respiratory events per hour of sleep confirmed by a sleep study.
- ❑ One of the following signs or symptoms are present:
  - ❑ Daytime sleepiness
  - ❑ Nonrestorative sleep
  - ❑ Fatigue
  - ❑ Insomnia
  - ❑ Waking up with breath holding, gasping, or choking
  - ❑ Habitual snoring noted by a bed partner or other observer
  - ❑ Observed apnea
- ❑ The recipient has used a standard treatment for the underlying obstruction for one month or longer (e.g., CPAP, BiPAP).
- ❑ The recipient is fully compliant with ongoing treatments for underlying airway obstruction.
- ❑ The recipient has tried and failed or has a contraindication to both modafinil or armodafinil.
- ❑ If the request is for **continuation of therapy**, has the recipient experienced a documented positive clinical response to Sunosi® therapy and has the recipient continued to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP)? (Attach supporting documentation to request) ❑ **Yes** ❑ **No** ❑ **N/A**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.

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