Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Narcolepsy Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Narcolepsy Agents.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

□ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication:

- ☐ Narcolepsy *(sleep study must be attached)*
- ☐ Excessive daytime sleepiness (EDS) in adult members with narcolepsy
- ☐ Obstructive sleep apnea *(sleep study must be attached)*
- ☐ Sudden onset of weak or paralyzed muscles (cataplexy)

☐ Shift work sleep disorder:

☐ Current shift schedule: _____

☐ Does not occur during the course of another sleep disorder or mental disorder

☐ Is not due to the direct physiological effects of a medication or a general medical condition

☐ Other: _____

Clinical Criteria:

1. Member is ≥ 18 years of age
   □ No □ Yes

Preferred Medication: modafinil, armodafinil, Sunosi

For Sunosi:

1. Member has tried and failed or there is contraindication to modafinil or armodafinil?

   □ No □ Yes

List pharmaceutical agents attempted and outcome: _____
_____

For Wakix:

1. Diagnosis of narcolepsy consistent with the International Classification of Sleep Disorder (ICSD-3) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)?; **AND**

   □ No □ Yes

2. Baseline daytime sleepiness as measured by a validated scale? (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale); **AND**

   □ No □ Yes

3. A mean sleep latency of ≤ 8 minutes AND ≥ 2 sleep onset REM periods (SOREMPs) are found on a mean sleep latency test (MSLT) performed according to standard techniques (A SOREMP [within 15 minutes of sleep onset] on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT); **AND**

   □ No □ Yes

4. Either cerebrospinal fluid (CSF) hypocretin-1 concentration has not been measured OR CSF hypocretin-1 concentration measured by immunoreactivity is either > 110 pg/mL OR > 1/3 of mean values obtained in normal subjects with the same standardized assay; **AND**

   □ No □ Yes

5. The hypersomnolence and/or MSLT findings are not better explained by other causes such as insufficient sleep, obstructive sleep apnea, delayed sleep phase disorder, or the effect of medication or substances or their withdrawal; **AND**

   □ No □ Yes

6. Daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for ≥ 3 months; **AND**

□ No □ Yes

7. Patient is not receiving treatment with sedative-hypnotic agents (e.g., zolpidem, eszopiclone, zaleplon, benzodiazepines, barbiturates); **AND**

   □ No □ Yes

8. Patient is not using drugs that prolong the QT interval (e.g., quinidine, procainamide, disopyramide, amiodarone, sotalol, ziprasidone, chlorpromazine, thioridazine, moxifloxacin) concomitantly; **AND**

   □ No □ Yes

9. Patient is not using histamine-1 (H1) receptor antagonists (e.g., pheniramine maleate, diphenhydramine, promethazine, imipramine, clomipramine, mirtazapine) concomitantly; **AND**

   □ No □ Yes

10. Patient does not have a history of prolonged QTc interval (e.g., QTc interval > 450 milliseconds); **AND**

    □ No □ Yes

11. Therapy is not being used in patients with severe hepatic impairment (Child-Pugh C); **AND**

    □ No □ Yes

12. Patient does not have end-stage renal disease (ESRD) (e.g., eGFR < 15 mL/minute/1.73 m_2).

    □ No □ Yes

13. Member tried and failed or there is contraindication to the preferred product:

    □ No □ Yes

For brand Nuvigil or Provigil:

1. Has the member tried and failed the preferred generics for the requested products?

   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Does the member continue to meet initial criteria? **AND**

   □ No □ Yes

2. Does the member report a reduction in excessive daytime sleepiness from pre-treatment baseline? **AND**

   □ No □ Yes

3. Has the member experienced any adverse effects related to treatment?

   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**