AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Sunosi® (solriamfetol)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

- **Diagnosis of narcolepsy must be in accordance with the third edition of the International Classification of Sleep Disorders (ICSD-3), which is a fully revised version of the American Academy of Sleep Medicine's manual of sleep disorders nosology, published in cooperation with international sleep societies and is the key reference work for the diagnosis of sleep disorders**.
- **Xyrem for narcolepsy with or without cataplexy will not be approved in conjunction with Sunosi**. **AvMed considers the use of concomitant therapy with Xyrem and Sunosi to be experimental and investigational. Safety and efficacy of these combinations has not been established and will not be permitted. In the event a member has an active Sunosi authorization on file, all subsequent requests for Xyrem will not be approved.**

****The maximum daily dose for this medication is 150 mg/day and requires renal dose adjustment****

Dosing Recommendations Based on Renal Function		
Estimated GFR	**Initial Dose**	**Maximum Dose**
30-59 mL/min	**37.5 mg once daily**	**75 mg once daily**
15-29 mL/min	**37.5 mg once daily**	**37.5 mg once daily**
<15 mL/min	**Not Recommended**	**Not Recommended**

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

DIAGNOSIS: Please check **ONE** of the applicable diagnoses below

❑ **Narcolepsy** (All applicable boxes below must be met to qualify)

- ❑ Member 18 years of age or older
- ❑ Member does **NOT** have a history of alcohol, drug or stimulant abuse
- ❑ Members with a history of psychosis of bipolar disorders are being observed for possible emergence or exacerbation of psychiatric symptoms
- ❑ Member's blood pressure and heart rate has been assessed and is adequately controlled prior to initiating treatment and will be monitored regularly during treatment
- ❑ Member has a diagnosis of excessive daytime sleepiness associated with narcolepsy with or without cataplexy **(MSLT confirming diagnosis of narcolepsy must be submitted)**
- ❑ Member has failed a 30-day trial of modafinil or armodafinil **(verified by chart notes or paid pharmacy claims)**

❑ **Obstructive Sleep Apnea** (All applicable boxes below must be met to qualify)

- ❑ Member is 18 years of age or older
- ❑ Member does **NOT** have a history of alcohol, drug or stimulant abuse
- ❑ Members with a history of psychosis of bipolar disorders are being observed for possible emergence or exacerbation of psychiatric symptoms
- ❑ Member's blood pressure and heart rate has been assessed and is adequately controlled prior to initiating treatment and will be monitored regularly during treatment
- ❑ Member has a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea **(polysomnogram confirming diagnosis of OSA must be submitted with request)**
- ❑ Member has failed a 30-day trial of modafinil or armodafinil **(verified by chart notes or paid pharmacy claims)**
- ❑ Medication is **NOT** being used as primary treatment of underlying airway obstruction
- ❑ Standard treatment(s) for the underlying obstruction (e.g., with continuous positive airway pressure [CPAP], bi-level positive airway pressure [BiPAP]) have been used for one month or longer and have been properly titrated
- ❑ Member is fully compliant with ongoing treatments(s) for the underlying airway obstruction

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy and Therapeutics Committee**: 9/19/2019
REVISED/UPDATED: ~~10/14/2019, 8/31/2020;~~ ~~10/11/2021;1/31/2023;~~ **10/30/2023**