Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Sunosi (solriamfetol)
Wakix (pitolisant)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ICD10:
☐ Sunosi 75mg ☐ Sunosi 150mg
☐ Wakix 4.45mg ☐ Wakix 17.8mg
☐ Other (please specify): _____

Directions for use: Quantity requested:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose new start of therapy. ☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had a positive response to therapy with this drug?
Notes: You may answer yes if there is a previously approved authorization, overturned appeals, or paid pharmacy claims for this medication. ☐ Yes ☐ No

(if Sunosi requested) Is this drug being prescribed by or in consultation with a neurologist, pulmonologist or sleep specialist? ☐ Yes ☐ No
(if Sunosi requested) Please provide clinical support for any dosing over 1 tablet/day, including past doses tried and results:

(if Wakix requested) Is this drug being prescribed by or in consultation with a neurologist or sleep specialist? ☐ Yes ☐ No
(if Wakix requested) Please provide clinical support for any dosing over 2 tablet/day, including past doses tried and results:

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ excessive daytime sleepiness associated with narcolepsy
☐ excessive daytime sleepiness associated with obstructive sleep apnea (OSA)
☐ other (please specify):

Clinical Information:

****For Wakix ONLY: This drug requires supportive documentation (chart notes, sleep study, etc). Supportive documentation for all answers must be attached with this request****

(if Wakix) Did your patient have ANY of the following tests:
☐ polysomnogram (PSG)
☐ multiple sleep latency test (MSLT)?

☐ Yes, ONLY a polysomnogram (PSG)
☐ Yes, ONLY a multiple sleep latency test (MSLT)
☐ Yes, BOTH a polysomnogram (PSG) and a multiple sleep latency test (MSLT)
☐ No, neither of the above

(if Wakix) Has your patient had a documented failure/inadequate response, intolerance, OR does your patient have a contraindication per FDA label or is not a candidate (for example, individual has a history of misuse or abuse of controlled substances) for ONE of the following:
A) armodafinil (generic for Nuvigil)
-OR-
B) modafinil (generic for Provigil)? ☐ Yes ☐ No

Will the patient use stimulant medications (for example, armodafinil, amphetamine, dextroamphetamine/ amphetamine, methylphenidate, modafinil, solriamfetol) in combination with Wakix for narcolepsy?
Notes: Nuvigil is brand armodafinil;
Adzenys XR-ODT, Adzenys ER, Dyanavel XR, Evekeo are brand amphetamine;
Adhansia XR, Concerta, Cotempla XR-ODT, Daytrana, Jornay PM, QuilliChew ER, Quillivant XR, Ritalin, Ritalin LA are brand methylphenidate;
Provigil is brand modafinil;
Sunosi is brand solriamfetol ☐ Yes ☐ No

(if Sunosi and narcolepsy) Does your patient have documented failure/ inadequate response or intolerance to ONE of the following:
A) amphetamine (generic for Evekeo)
B) Armodafinil (generic for Nuvigil) OR modafinil (generic for Provigil)
C) dextroamphetamine/amphetamine (generic for Adderall)
D) dextroamphetamine (generic for Dexedrine or Zenzedi) OR ProCentra (dextroamphetamine solution)
E) methylphenidate chewable tablet OR methylphenidate tablet (generic for Ritalin) OR methylphenidate oral solution (generic for Methylin)? ☐ Yes ☐ No

(if no) Does your patient have contraindication per FDA label or is NOT a candidate for ONE of the following:
A) amphetamine (generic for Evekeo)
B) Armodafinil (generic for Nuvigil) OR modafinil (generic for Provigil)
C) dextroamphetamine/amphetamine (generic for Adderall)
D) dextroamphetamine (generic for Dexedrine or Zenzedi) OR ProCentra (dextroamphetamine solution)
E) methylphenidate chewable tablet OR methylphenidate tablet (generic for Ritalin) OR methylphenidate oral solution (generic for Methylin)? ☐ Yes ☐ No

(if Sunosi and OSA) Does your patient have documented failure/ inadequate response or intolerance to ONE of the following:
A) armodafinil (generic for Nuvigil)
-OR-
B) modafinil (generic for Provigil)? ☐ Yes ☐ No

(if no) Does your patient have contraindication per FDA label or is NOT a candidate for ONE of the following:
A) armodafinil (generic for Nuvigil)
-OR-
B) modafinil (generic for Provigil)? ☐ Yes ☐ No

(if narcolepsy) Is there documentation that your patient has had daily periods of irrepressible need to sleep or lapses into sleep during waking hours, occurring for at least three months? ☐ Yes ☐ No
(if narcolepsy) Did your patient have a nocturnal polysomnography (PSG) to rule out other causes of excessive daytime sleepiness? ☐ Yes ☐ No
(if narcolepsy) Did your patient have a multiple sleep latency test (MSLT) that showed a mean sleep latency of 8 minutes or less? ☐ Yes ☐ No
(if narcolepsy) Did your patient have any sleep-onset rapid eye movement periods (SOREMPs) during the MSLT?
☐ Yes, 2 or more SOREMPs
☐ Yes, only 1 SOREMP
☐ No or Unknown

(if only 1 SOREMP) Did your patient have a SOREMP within 15 minutes of sleep onset during the nocturnal PSG? ☐ Yes ☐ No

(if OSA) Was the diagnosis confirmed by sleep study? ☐ Yes ☐ No
(if OSA) Has your patient had an inadequate response to at least 3 months of non-pharmacologic treatment for OSA [for example, continuous positive airway pressure (CPAP)]? ☐ Yes ☐ No
(if OSA) Will your patient use this drug in combination with non-pharmacologic OSA therapies (e.g. oral appliances, surgery, or continued use of PAP)? ☐ Yes ☐ No

Additional Pertinent Information: *(please include details for each drug tried previously for this diagnosis such as drug name, date(s) taken and for how long, and what the documented results were of taking it, including any intolerances or adverse reactions your patient experienced OR include any drugs your patient cannot take either due to contraindication per FDA or health reason [be sure to include the reason why they cannot use them]):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

V040620