UnitedHealthcare Community Plan

Anti Narcolepsy Agents - Washington

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: ______________

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ________________

Section B - Provider Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? ______________**

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Indicate the patient's diagnosis
☐ Narcolepsy with Excessive Daytime Sleepiness confirmed with a sleep study and multiple sleep latency test
☐ Narcolepsy with Cataplexy confirmed with a sleep study and multiple sleep latency test
☐ Obstructive Sleep Apnea with Excessive Daytime Sleepiness confirmed with a sleep study
☐ Shift Work Sleep Disorder
☐ Other. Specify: ________________

2. Does patient have a history of failure as stated below, contraindication, or intolerance to any of the following (mark all that apply)
☐ Modafinil (Provigil) for a minimum of 60 consecutive days
☐ Armodafinil (Nuvigil) for a minimum of 60 consecutive days
☐ Amphetamine or methylphenidate-based stimulant for a minimum of 60 consecutive days.
☐ Solriamfetol (Sunosi) for a minimum of 30 consecutive days
☐ Other contraindication or intolerance. Specify drug and describe: _________________________

3. Is the medication prescribed by, or in consultation with, a neurologist, psychiatrist, or sleep specialist?
☐ Yes ☐ No

4. Has patient had a quantitative assessment completed within the last 6 months (e.g., Epworth Sleepiness Scale, Maintenance of Wakefulness Test)? ☐ Yes ☐ No

5. Is this request for a continuation of therapy? ☐ Yes ☐ No
If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

For diagnosis of Narcolepsy with Cataplexy, please answer the following:

6. Does patient have clinical documentation that supports any of the following (check all that apply):
☐ Presence of cataplexy (e.g., documented episodes of sudden loss of muscle tone)
☐ Impairment/limitation of activities of daily living (e.g. unable to attend school, unable to attend work, unable to drive)?

7. For continuation of therapy requests, does patient have clinical documentation showing a reduction in cataplexy events? ☐ Yes ☐ No

For diagnosis of Obstructive Sleep Apnea with Excessive Daytime Sleepiness, please answer the following:

8. Has the patient achieved normalized breathing and oxygenation with continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP)? ☐ Yes ☐ No

9. Does patient have documentation within the past 6 months, demonstrating adherence to any of the following (check all that apply)?
☐ CPAP or BIPAP therapy (CPAP or BIPAP is used for 70% of nights for a minimum of 4 hours per night)
☐ Mandibular advancement device
☐ Other. Specify: ________________

For diagnosis of Shift Work Sleep Disorder, please answer the following:

10. Is there clinical documentation demonstrating concomitant use of nonpharmacologic interventions (i.e., counseling, sleep hygiene)? ☐ Yes ☐ No

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Member First name:	Member Last name:	Member DOB:

All requests require chart notes

For diagnosis of narcolepsy, provide the following:

- Sleep study and multiple sleep latency test (MSLT)
- Quantitative assessment within the past 6 months (e.g. Epworth Sleepiness Scale, Maintenance of Wakefulness Test)
- For narcolepsy with cataplexy continuation of therapy requests, provide clinical documentation showing a reduction of cataplexy events.

For diagnosis of obstructive sleep apnea with excessive daytime sleepiness, provide the following:

- Sleep study
- Quantitative assessment within the past 6 months (e.g. Epworth Sleepiness Scale, Maintenance of Wakefulness Test)
- Documentation of adherence to CPAP/BIPAP therapy or mandibular advancement device compliance in the last 6 months

For continuation of therapy, provide clinical documentation demonstrating disease stability or a positive clinical response. For obstructive sleep apnea, documentation of adherence to CPAP/BiPAP or mandibular advancement device is required.

Prescriber signature	Prescriber specialty	Date

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