Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Armodafinil (Nuvigil), Solriamfetol (Sunosi) and Pitolisant (Wakix) – Medical Necessity Request

Complete pages 1 and 2 for Initial Requests

General Information:

1. **For Solriamfetol (Sunosi) and Pitolisant (Wakix) requests only**: Can the prescription be changed to modafinil or armodafinil?
   - □ Yes: Please notify the pharmacy of the change and proceed to next section.
   - □ No: Please provide the clinical reason(s) why both modafinil and armodafinil cannot be tried, then proceed to next section.

     _____

Contraindication Information:

1. **For Solriamfetol (Sunosi) requests only**: Will it be used together with a Monoamine Oxidase Inhibitor (MAOI - e.g., Rasagiline, Selegiline, Phenelzine and other similar drugs) or did the member use a MAOI within the past 14 days? **Yes or No**

2. **For Pitolisant (Wakix) requests only**: Does the member have severe hepatic impairment? **Yes or No**

3. For Armodafinil (Nuvigil) requests only: Does the member have known hypersensitivity to modafinil? Yes or No

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Narcolepsy

□ Obstructive sleep apnea/hypopnea syndrome (OSAHS)
- a. Does the member have excessive sleepiness? **Yes or No**
- b. Has the member been treated for the underlying obstruction with CPAP, BiPAP, oral appliances and/or surgery? **Yes or No**
  - If yes, please specify what the member has been treated with: _____
- d. Will the member continue to be treated with CPAP, BiPAP and/or oral appliances together with the requested medication? **Yes or No**

□ Shift work sleep disorder (SWSD)
- a. Does the member have excessive sleepiness? **Yes or No**
- b. Has the member been symptomatic for at least 3 months? **Yes or No**
- c. Does the member work at least 5 night shifts per month? **Yes or No**

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ Other: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Armodafinil (Nuvigil), Solriamfetol (Sunosi) and Pitolisant (Wakix) – Medical Necessity Request

Complete this page for Subsequent Requests

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Narcolepsy

□ Obstructive sleep apnea/hypopnea syndrome (OSAHS)

a. Will the member continue to be treated for the underlying obstruction with CPAP, BiPAP and/or oral appliances together with the requested medication? **Yes or No**

□ Shift work sleep disorder (SWSD)

a. Does the member work at least 5 night shifts per month? **Yes or No**

□ Other: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**