CAREFIRST - DC EXCHANGE 5T
Sunosi (HMF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Sunosi (HMF).

Patient Information

Patient Name:
Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐
Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐
Physician Addr.:
City, St, Zip:

Drug Name (select from list of drugs shown)

Sunosi (solriamfetol)

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____

Please check the appropriate answer for each applicable question.

1.	Does the patient have a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA)?	**Y** ☐	**N** ☐
2.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
3.	Has the patient achieved or maintained a decrease in daytime sleepiness with obstructive sleep apnea (OSA) from baseline?	**Y** ☐	**N** ☐
4.	Is the patient compliant with using continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP)?	**Y** ☐	**N** ☐
5.	Is the requested drug being prescribed by, or in consultation with, a sleep specialist?	**Y** ☐	**N** ☐
6.	Is the diagnosis confirmed by polysomnography?	**Y** ☐	**N** ☐
7.	Has the patient been receiving treatment for the underlying airway obstruction (continuous positive airway pressure [CPAP] or bilevel positive airway pressure [BIPAP]) for at least one month?	**Y** ☐	**N** ☐
8.	Will the patient continue to use continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) after the requested drug is started?	**Y** ☐	**N** ☐
9.	Does the patient have a diagnosis of excessive daytime sleepiness associated with narcolepsy?	**Y** ☐	**N** ☐
10.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
11.	Has the patient achieved or maintained a decrease in daytime sleepiness with narcolepsy from baseline?	**Y** ☐	**N** ☐
12.	Is the requested drug being prescribed by, or in consultation with, a sleep specialist?	**Y** ☐	**N** ☐

13.	Is the diagnosis confirmed by a sleep study?	**Y** ☐	**N** ☐
14.	Has the patient experienced an inadequate treatment response to armodafinil OR modafinil?	**Y** ☐	**N** ☐
15.	Has the patient experienced an intolerance to armodafinil OR modafinil?	**Y** ☐	**N** ☐
16.	Does the patient have a contraindication that would prohibit a trial of ALL of the following: A) armodafinil, B) modafinil?	**Y** ☐	**N** ☐
17.	Does the patient require MORE than the plan allowance of 30 tablets per month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date