

Member Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Member DOB: \_\_\_\_\_  
Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Directions: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Physician Fax #: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

**Horizon NJ Health**  
***Modafinil (Provigil), Armodafinil (Nuvigil) and Solriamfetol (Sunosi) – Medical Necessity Request***

**General Information:**

1. **For Solriamfetol (Sunosi) 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.
- \_\_\_\_\_

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

- Narcolepsy
  - a. Does the member have excessive sleepiness? **Yes or No**
- Obstructive sleep apnea/hypopnea syndrome (OSAHS)
  - a. Does the member have excessive sleepiness? **Yes or No**
  - b. Has the diagnosis been confirmed by polysomnography or home sleep apnea testing? **Yes or No**
  - c. 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**
  - e. Have other causes of excessive sleepiness been ruled out (e.g., non-compliance with CPAP, ill-fitting CPAP masks, insufficient sleep, poor sleep hygiene, etc.)? **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**
- Fatigue
  - a. What is the fatigue associated with?
    - Multiple Sclerosis
    - Depression (Please answer the questions listed under the diagnosis of Depression, p. 2)
    - Other: \_\_\_\_\_
- Multiple Sclerosis
  - a. Does the member have associated fatigue? **Yes or No**

*Continued on p. 2*

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: \_\_\_\_\_

Attention deficit hyperactivity disorder (ADHD)/ Attention deficit disorder (ADD)

a. Can the member try a formulary ADHD medication? **Yes or No** *NOTE: Formulary medications include: methylphenidate immediate-/extended-release preparation, immediate-release dexamethylphenidate, mixed-salts amphetamine immediate-/extended-release preparation, dextroamphetamine immediate-/sustained-release, atomoxetine, immediate-/extended release guanfacine.*

- If yes, please call the formulary ADHD medication prescription into the member's pharmacy.

- If no, please provide the clinical reason why a formulary medication cannot be tried?

\_\_\_\_\_

b. What medication(s) has the member tried for ADHD/ADD?

\_\_\_\_\_

Depression

a. Does the member have Major Depressive Disorder? **Yes or No**

b. Does the member have associated fatigue? **Yes or No**

c. Has the member tried and failed at least two antidepressant therapies (i.e. Fluoxetine, Paroxetine, Venlafaxine Duloxetine, Bupropion)? **Yes or No**

- If No, can the member try an antidepressant therapy? **Yes or No**

- If yes, please call the prescription into the member's pharmacy

- If no, please provide the clinical reason why

\_\_\_\_\_

d. Which medication(s) has the member tried?

\_\_\_\_\_

e. Will the member be receiving modafinil in combination with SSRI (selective serotonin reuptake inhibitor)? **Yes or No**

f. Does the member continue to have residual symptoms (i.e. fatigue, hypersomnolence)? **Yes or No**

Other: \_\_\_\_\_

Physician office's signature\* \_\_\_\_\_ Print Name \_\_\_\_\_

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***Modafinil (Provigil), Armodafinil (Nuvigil) and Solriamfetol (Sunosi) – 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**
- Fatigue
  - a. Is the fatigue associated with Multiple Sclerosis or Depression? **Yes or No**  
(For Depression, please answer the questions under depression)
- Multiple Sclerosis
  - a. Does the member have associated fatigue? **Yes or No**
- Depression
  - a. Does the member have Major Depressive Disorder? **Yes or No**
  - b. Does the member have associated fatigue? **Yes or No**
  - c. Will the member be receiving modafinil in combination with SSRI (selective serotonin reuptake inhibitor)? **Yes or No**
- Attention deficit hyperactivity disorder (ADHD)/ Attention deficit disorder (ADD)
- Other: \_\_\_\_\_

**Physician office's signature\*** \_\_\_\_\_ **Print Name** \_\_\_\_\_

**\*Form must be completed and signed by physician or licensed representative from the physician's office**