pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

STIMULANTS AND RELATED AGENTS – PROVIGIL / NUVIGIL / SUNOSI / WAKIX PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Stimulants and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Dx code (required):	
Will the beneficiary receive concurrent treatment with a sedative/hypnotic medication(s)?	☐Yes ☐No	*Submit documentation of current complete medication list.*

INITIAL Requests

For a non-preferred drug: Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred drugs in this class that are FDA-approved or medically accepted for the treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes ☐No	*Submit documentation.*

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐For treatment of narcolepsy:
- ☐Diagnosis is consistent with current International Classification of Sleep Disorders criteria (e.g., MSLT, overnight PSG, hypocretin-1 concentration, clinical assessment, etc.)

☐For treatment of shift work sleep disorder:
- ☐Diagnosis is consistent with current International Classification of Sleep Disorders criteria (e.g., shift work schedule, sleep log & actigraphy monitoring, other causes ruled out, clinical assessment, etc.)

☐For treatment of obstructive sleep apnea/hypopnea syndrome:
- ☐Diagnosis is consistent with current International Classification of Sleep Disorders criteria (e.g., overnight PSG, out-of-center sleep testing, associated medical or psychiatric disorders, clinical assessment, etc.)
- ☐Tried and failed continuous positive airway pressure (CPAP) while adherent to treatment to resolve daytime sleepiness demonstrated by:
  - ☐Epworth Sleepiness Scale >10
  - ☐Multiple sleep latency test (MSLT) <8 minutes
- ☐Cannot use CPAP – reason: _____
  - ☐Tried and failed an oral appliance for OSAHS to resolve daytime sleepiness

☐For treatment of fatigue related to multiple sclerosis:
- ☐Is currently receiving treatment for MS
- ☐Is not receiving treatment for MS – reason: _____

RENEWAL Requests

Has the beneficiary experienced a positive clinical response since starting the requested medication? *Submit documentation.*	☐Yes ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: