Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Antinarcolepsy: Sunosi

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Sunosi** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): Initial Authorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days
   Reauthorization: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

1. Is the member 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member have an adequate documented trial and failure of, or contraindication to, Provigil or Nuvigil? ☐ **Yes** ☐ **No** Please explain trial and failure or contraindication: _____
   _____
3. Does the member have a diagnosis of obstructive sleep apnea (OSA)? ☐ **Yes** ☐ **No**
4. Does the member have a diagnosis of narcolepsy? ☐ **Yes** ☐ **No**
5. Does the member have end stage renal disease (estimated glomerular filtration rate [eGFR] <15ml/min/1.73m2)? ☐ **Yes** ☐ **No**
6. Has the member's blood pressure been assessed, and hypertension controlled (< 140/90 mmHg) prior to initiating treatment? ☐ **Yes** ☐ **No**
7. Has the member received an MAO inhibitor within the previous 14 days? ☐ **Yes** ☐ **No**
8. Is the member receiving concomitant noradrenergic medications? ☐ **Yes** ☐ **No**
9. If using to treat OSA, does the provider attest that the member is compliant with and will continue using positive airway pressure (PAP)? ☐ **Yes** ☐ **No**
10. If using to treat OSA, has the prescriber excluded any other identifiable causes for member's sleepiness (e.g. non-compliance with PAP, improperly fitted AP mask, insufficient sleep, poor sleep hygiene, depression, and/or other sleep disorders)? ☐ **Yes** ☐ **No**

For continuation of therapy, please answer questions 1-12

11. Has the member developed increased blood pressure or heart rate that was not controlled by dose reduction of solriamfetol (Sunosi) or medical intervention? ☐ **Yes** ☐ **No**
12. Has the member reported a documented reduction in excessive daytime sleepiness from pre-treatment baseline as measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277