Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Sunosi (Solriamfetol) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Sunosi (Solriamfetol) (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
SUNOSI 150MG TABLET	SUNOSI 75MG TABLET

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 18 years of age? Y N
   If the anwer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of narcolepsy in the past 730 days? Y N
   If the anwer to this question is yes, go to question 6.
   If the answer to this question is no, go to question 4.

4. Does the patient have a diagnosis of obstructive sleep apnea in the last 730 days? Y N
   If the anwer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the patient have a procedure code for continuous positive airway pressure (CPAP) Y N

or Biphasic Intermittent Positive Airway Pressure (BiPAP) in the last 730 days?
If the anwer to this question is yes, go to question 6.
If the answer to this question is no, denied.

6. Does the patient have at least 30 days therapy of modafinil or armodafinil in the last 365 days? Y N
If the anwer to this question is yes, go to question 7.
If the answer to this question is no, denied.

7. Does the patient have a claim for a monoamine oxidase (MAO) inhibitor in the last 90 days? Y N
If the anwer to this question is yes, denied.
If the answer to this question is no, go to question 8.

8. Does the patient have a diagnosis of end stage renal disease (ESRD) or dialysis in the last 365 days? Y N
If the anwer to this question is yes, denied.
If the answer to this question is no, go to question 9.

9. Is the daily dose less than or equal to 1 tablet daily? Y N
If the anwer to this question is yes, go to question 10.
If the answer to this question is no, denied.

10. Is this request for a non-preferred drug? Y N
If the anwer to this question is yes, go to question 11.
If the answer to this question is no, approved for 365 days.

11. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 12.

12. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 13.

13. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date