HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

STIMULANTS AND RELATED AGENTS – ANALEPTICS (e.g., PROVIGIL / NUVIGIL / SUNOSI / WAKIX)

PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

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.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html.

☐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:		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.*	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. **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.)
2. **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.)
3. **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

4. **For treatment of fatigue related to multiple sclerosis:**

☐ Is currently receiving treatment for MS

☐ Is not receiving treatment for MS – reason: _____

5. **For a NON-PREFERRED analeptic Stimulants and Related Agent:**

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred analeptic Stimulants and Related Agents that are approved or medically accepted for treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

RENEWAL requests

1. **For all requests:**

☐ Experienced a positive clinical response to the requested analeptic

2. **For a NON-PREFERRED analeptic Stimulants and Related Agent:**

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred analeptic Stimulants and Related Agents that are approved or medically accepted for treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: