US Family Health Plan
Prior Authorization Request Form for
Solriamfetol (Sunosi)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior Authorization expires after 1 year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	______________________	Physician Name:	______________________
Address:	______________________	Address:	______________________
	______________________		______________________
Sponsor ID #:	______________________	Phone #:	______________________
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

Question		
1. Does the provider acknowledge that a prior authorization is not required for modafinil or armodafinil?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ excessive daytime sleepiness associated with narcolepsy – proceed to question **4** ☐ excessive daytime sleepiness associated with obstructive sleep apnea (OSA) – proceed to question **9** ☐ Other diagnosis - **Coverage not approved**	
4. Is the requested medication being prescribed by a neurologist, psychiatrist, or sleep medicine specialist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has narcolepsy been diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Have other causes of sleepiness been ruled out or treated including, but not limited to, obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications, or other sleep disorders?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Has the patient tried and failed, had a contraindication to, or intolerance to modafinil or armodafinil?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried and failed, had a contraindication to, or intolerance to stimulant-based therapy (amphetamine-based therapy or methylphenidate)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
9. Is the requested medication being prescribed by a specialist who treats patients with obstructive sleep apnea (for example, pulmonologist, cardiologist, sleep medicine)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient's underlying airway obstruction been treated with continuous positive airway pressure (CPAP) for at least 1 month prior to initiation, and the patient demonstrated adherence to therapy during this time?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient continue treatment for underlying airway obstruction (CPAP or similar) throughout duration of treatment?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Has the patient tried and failed, had a contraindication to, or intolerance to modafinil or armodafinil?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will there be concurrent use with a central nervous system depressant, such as a narcotic analgesic (including tramadol), a benzodiazepine, or a sedative hypnotic?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature ______________________ Date ____________

[08 January 2025]