

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>.

<input type="checkbox"/> New request	<input type="checkbox"/> 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 (<i>submit documentation</i>):	DX code (required):	
Will the beneficiary receive concurrent treatment with a sedative/hypnotic medication(s)?	<input type="checkbox"/> Yes <i>Submit documentation of current complete medication list.</i> <input type="checkbox"/> No	

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:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.