

IA Medicaid Member ID # _ _ _ _ _ _ _ _ _ _	Patient name	DOB
Patient address 		
Provider NPI _ _ _ _ _ _ _ _ _ _	Prescriber name	Phone
Prescriber address 		Fax
Pharmacy name	Address 	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI _ _ _ _ _ _ _ _ _ _	Pharmacy fax 	NDC _ _ _ _ _ _ _ _ _ _

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Excessive Daytime Sleepiness associated with Narcolepsy (Please provide results from ESS, MSLT, and PSG verified by a sleep specialist)**

Trial of modafinil: Dose: _____

Trial Dates: _____

Failure Reason: _____

☐ **Idiopathic Hypersomnia (Please provide results from ESS, MSLT, and PSG verified by a sleep specialist)**

Trial of modafinil: Dose: _____ **Trial Dates:** _____

Failure Reason: _____

Will medication be used in combination with other oxybate products or with pitolisant and/or solriamfetol?

☐ Yes ☐ No

Patient has been counseled and will be closely monitored for signs of abuse: ☐ Yes ☐ No

Prescriber review of patient's controlled substances use on the Iowa PMP website:

☐ Yes Date Reviewed: _____ ☐ No

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.