Solriamfetol Titration & AdministRaTion (START) in Patients With Obstructive Sleep Apnea: A Retrospective Chart Review and Hypothetical Patient Scenario

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PEER-REVIEWED FEATURE

How do physicians prescribing solriamfetol for patients with excessive daytime sleepiness (EDS) in OSA formulate and execute initiation and titration strategies?

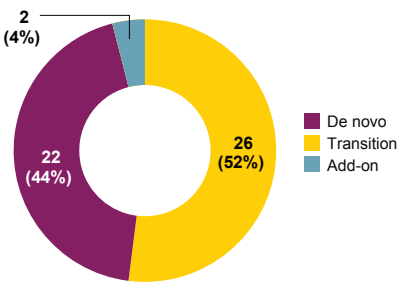
Study Design

- **26 US-based physicians** prescribing solriamfetol participated in a retrospective chart review and 24 provided data from 50 patients with OSA
- **Solriamfetol initiation** strategies were categorized as:
  - **de novo** – EDS medication-naive
  - **transition** – switched/switching from existing EDS medication(s) to solriamfetol
  - **add-on** – adding solriamfetol to current EDS medication(s)

Results

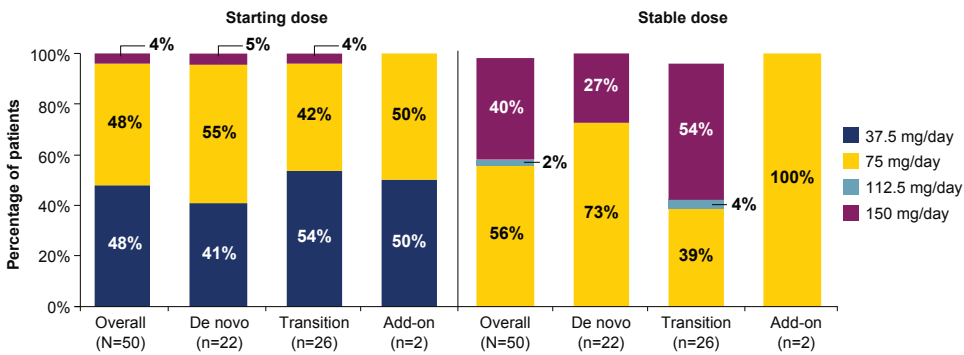
Patients with OSA

Solriamfetol initiation was de novo for 44% (n=22), **transition** for 52% (n=26), and **add-on** for 4% (n=2) of patients



Efficacy was the primary reason for starting solriamfetol, regardless of whether initiation was de novo (82%), transition (58%), or add-on (100%)

Patients typically started solriamfetol at 37.5 or 75 mg/day and were stable at 75 or 150 mg/day



14 days

Most patients (64%) had 1 dose adjustment, and median time to a stable dose was 14 days

96% of patients were still on a stable dose of solriamfetol at data collection

Physicians abruptly discontinued wake-promoting agents (17/18, 94%) and stimulants (6/9, 67%) for transitioning patients

Key Takeaway

Physicians typically started solriamfetol due to its efficacy profile or a desire for improved efficacy, initiated solriamfetol at 37.5 mg/day or 75 mg/day, and made 1 adjustment to reach a stable dose of solriamfetol over a median of 14 days. Most patients (96%) were stable on solriamfetol at the time of data collection.