HIGHMARK

PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

PROVIGIL (MODAFINIL)/NUVIGIL (ARMODAFINIL) PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber ID Number		Group Number	
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician Name	Phone		Fax
Physician Address	City	State	Zip Code
Suite / Building	Physician Signature		Date

MEDICATION INFORMATION

Requested Drug: ☐ Brand Provigil ☐ Generic Modafinil	☐ Brand Nuvigil ☐ Generic Armodafinil
Requested Strength: ☐ 100mg ☐ 200mg	☐ 50mg ☐ 150mg ☐ 200mg ☐ 250mg
Diagnosis:	Quantity **per Month**

CLINICAL CRITERIA

If the request is for **brand Provigil** or **brand Nuvigil**, has the patient experienced therapeutic failure or intolerance to:

Generic Modafinil? ☐ Yes ☐ No Generic Armodafinil? ☐ Yes ☐ No

Is this a request for reauthorization? ☐ Yes ☐ No

If **YES**, please select **ALL** that apply:

☐ The patient's symptoms (e.g. fatigue) have improved
☐ The patient has experienced improvement in daytime sleepiness
☐ The patient experienced improvement on the ESS** or MWT*** compared to baseline

**Epworth Sleepiness Scale
***Maintenance of Wakefulness Test

If the requested medication is being used to treat **obstructive sleep apnea**, please answer the following:

1. Is the patient currently receiving and compliant with continuous positive airway pressure (CPAP)?
   ☐ Yes ☐ No

2. Is the patient experiencing any of the following symptoms? Please select **ALL** that apply:
   ☐ Coronary artery disease ☐ Unrefreshing sleep ☐ Mood disorder ☐ Insomnia
   ☐ Congestive heart failure ☐ Cognitive dysfunction ☐ Atrial fibrillation ☐ Fatigue
   ☐ Type 2 diabetes mellitus ☐ Daytime sleepiness ☐ Hypertension ☐ Stroke
   ☐ Unintentional sleep episodes during wakefulness ☐ Waking up holding breath, gasping, or choking
   ☐ Bed partner describes loud snoring, breathing interruptions or both

3. Please provide the following from the patient's **diagnostic** polysomnography:

   Patient's apnea/hypopnea index (AHI) in events/hour: _____

If the requested medication is being used to treat **narcolepsy**, please answer the following:

1. Please provide baseline data of the following:

   Excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS): _____

   Maintenance of Wakefulness Test (MWT): _____

2. Please provide the following results of the patient's multiple sleep latency test (MSLT):

   Mean sleep latency (in minutes): _____

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____

3. Please provide the following from the patient's polysomnography:

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____

4. If the member has hypocretin-1 deficiency, please provide the following:

   Cerebrospinal fluid hypocretin-1 level (in pg/mL): _____

   Cerebrospinal fluid hypocretin-1 laboratory reference range): _____

If the requested medication is being used to treat **shift-work sleep disorder**, please answer the following:

1. Does the patient work a minimum of 5 night shifts per month?
   ☐ Yes ☐ No
2. Does the patient work at least 3 consecutive night shifts per month?
   ☐ Yes ☐ No
3. Are the patient's night shifts a minimum of 6 hours in duration?
   ☐ Yes ☐ No
4. Are the patient's night shifts more than 12 hours in duration?
   ☐ Yes ☐ No
5. Do the patient's night shifts occur between 10:00 PM and 8:00 AM?
   ☐ Yes ☐ No

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**