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

NUVIGIL (ARMODAFINIL) PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber's ID Number	Subscriber's Group Number

Patient's Name	Phone	Date of Birth

Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician's Name	NPI	Phone	Fax

Address	City	State	Zip Code

Suite / Building	Physician's Signature	Date

MEDICATION INFORMATION

Requested Drug:	Requested Strength:
☐ Brand Nuvigil ☐ Generic Armodafinil	☐ 50mg ☐ 150mg ☐ 200mg ☐ 250mg

Diagnosis:	Quantity **per Month**

CLINICAL CRITERIA

OBSTRUCTIVE SLEEP APNEA

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
   ☐ Congestive heart failure
   ☐ Type 2 diabetes mellitus
   ☐ Unintentional sleep episodes during wakefulness
   ☐ Bed partner describes loud snoring, breathing interruptions or both
   ☐ Unrefreshing sleep
   ☐ Mood disorder
   ☐ Insomnia
   ☐ Cognitive dysfunction
   ☐ Atrial fibrillation
   ☐ Fatigue
   ☐ Daytime sleepiness
   ☐ Hypertension
   ☐ Stroke
   ☐ Waking up holding breath, gasping, or choking
3. Please provide the following from the patient's **diagnostic** polysomnography:

   Apnea/hypopnea index (AHI) in events/hour: _____

NARCOLEPSY

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 diagnostic polysomnography:

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

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

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

   Cerebrospinal fluid hypocretin-1 laboratory reference range: _____

5. Has the patient experienced therapeutic failure, contraindication, or intolerance to a generic CNS stimulant (e.g. dextroamphetamine, methylphenidate)?
   ☐ Yes ☐ No

SHIFT-WORK SLEEP DISORDER

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

1. Does the patient have excessive sleepiness or insomnia that is temporarily associated with a recurring work schedule that overlaps the usual time for sleep?
   ☐ Yes ☐ No

2. Are the patient's symptoms accompanied by a reduction of total sleep time?
   ☐ Yes ☐ No

3. Has the patient experienced symptoms for at least 3 months?
   ☐ Yes ☐ No

4. Does the patient have sleep log or actigraphy monitoring for at least 14 days including both work and free days?
   ☐ Yes ☐ No

5. Is the patient's sleep disturbance due to another current sleep disorder, medical or neurological disorder, mental disorder, medication use, or substance use disorder?
   ☐ Yes ☐ No

REAUTHORIZATION

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

MEDICATION HISTORY

Please provide any other medications previously tried and failed for the patient's diagnosis:

_____

_____

_____

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**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222