



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: <input type="checkbox"/> Brand Provigil <input type="checkbox"/> Generic Modafinil	<input type="checkbox"/> Brand Nuvigil <input type="checkbox"/> Generic Armodafinil
Requested Strength: <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg	<input type="checkbox"/> 50mg <input type="checkbox"/> 150mg <input type="checkbox"/> 200mg <input type="checkbox"/> 250mg
Diagnosis:	Quantity <u>per Month</u>

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:

- Is the patient currently receiving and compliant with continuous positive airway pressure (CPAP)?
 Yes No
- 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
- 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**

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