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2020 modafinil (generic Provigil®) or armodafinil (generic Nuvigil®) Prior Authorization Request

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(You must complete both pages.)

Fax completed form to: 1-800-408-2386 **For urgent requests, please call: 1-800-414-2386**

Coverage Criteria:

- Covered for a diagnosis of shift work disorder (SWD)
- Covered for the treatment of narcolepsy if the diagnosis of narcolepsy was confirmed by sleep lab evaluation
- Covered for the treatment of excessive sleepiness associated with obstructive sleep apnea (OSA) if the diagnosis of obstructive sleep apnea (OSA) was confirmed by polysomnography

Authorization duration: Through end of plan contract year

Patient information		**Prescriber information**	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		M.D. office telephone number	
Gender ☐ Male ☐ Female	Patient date of birth	M.D. office fax number	

Diagnosis and medical information

Medication requested	**Frequency**		
☐ modafinil tablet: ☐ 100mg ☐ 200mg ☐ armodafinil tablet: ☐ 50mg ☐ 150mg ☐ 200mg ☐ 250mg			
New prescription OR date therapy initiated	**Quantity**	**Day supply**	**Expected length of therapy**

Diagnosis (*Please check all boxes that apply and include all office notes supporting diagnosis.)*

☐ Narcolepsy ☐ Obstructive sleep apnea (OSA) ☐ Shift work disorder (SWD)
☐ Other diagnosis/(ICD 10): _____

Please check all boxes that apply:

1. ☐ **Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result in adverse clinical outcomes.**
2. ☐ **All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.**
3. ☐ Yes ☐ No **To improve wakefulness in adult patients with excessive sleepiness associated with NARCOLEPSY: Has the diagnosis of narcolepsy been confirmed by sleep lab evaluation?**
4. ☐ Yes ☐ No **To improve wakefulness in adult patients with excessive sleepiness associated with OBSTRUCTIVE SLEEP APNEA (OSA): Has the diagnosis of OSA been confirmed by polysomnography?**

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Please check all boxes that apply (continued):

5. **Please complete this section only if your patient does not meet the standard requirements listed in question 3 and 4 above**:
Please explain why your patient should be considered for an exception although they don't meet the plan's suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement. (Please note any information that is incomplete or illegible will delay the review process.)

_____

_____

_____

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6. ☐ Yes ☐ No **Modafinil 100mg and ALL strengths of armodafinil have a quantity limit of 30 tablets per 30 days. Modafinil 200mg has a quantity limit of 60 tablets per 30 days.**

Does the patient require higher dosage (quantity limit exception)?

►If yes, indicate quantity requested: _____ per 30 days OR quantity _____ per day

☐ The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.

☐ The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

7. ☐ **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

8. ☐ **Other supporting information**

*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

_____

_____

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_____

_____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	**Date**