AmeriHealth

Prior Authorization Form

Provigil® (modafinil)/Nuvigil® (armodafinil)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: ☐ **Provigil®** (modafinil) ☐ **Nuvigil®** (armodafinil)

Date _____ Patient's ID#: _____ DOB: _____

Patient's Name _____ Provider NPI: _____

Prescribing Physician _____ Office Contact: _____

Office Fax# _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. **PROVIDER SPECIALTY** (specify): ☐ Neurologist ☐ Sleep Specialist ☐ Other: _____
2. **DIAGNOSIS FOR DRUG REQUESTED:**
   - ☐ Narcolepsy
   - ☐ Idiopathic Hypersomnia
   - ☐ Obstructive Sleep Apnea/Hypopnea Syndrome
   - ☐ Shift Work Sleep Disorder
   - ☐ Fatigue associated with multiple sclerosis
   - ☐ Other (*specify*): _____
3. **PATIENT HISTORY:**

a. Was a sleep study conducted? Diagnosis *(resulting from sleep study)*:_____	☐ **Yes** ☐ **No** ☐ **N/A** _____
b. Clinical evaluation demonstrating presence of a shift work schedule likely to result in sleepiness?	☐ **Yes** ☐ **No** ☐ **N/A**
c. Clinical evaluation showing failure of patient counseling regarding techniques for reducing the negative effects of shift work (napping, bright light, avoidance, or request for change in shift, etc.)?	☐ **Yes** ☐ **No** ☐ **N/A**
d. Does the patient have a history of medical or mental disorder that accounts for the symptoms?	☐ **Yes** ☐ **No** ☐ **N/A**
e. Does the patient have any sleep disorders that produce insomnia or excessive sleepiness (e.g. time-zone change syndrome)?	☐ **Yes** ☐ **No** ☐ **N/A**
f. Does the patient have a primary complaint of insomnia or excessive sleepiness temporarily associated with work period that occurs during the habitual sleep phase or Polysomnography and the multiple sleep latency test (MSLT) that demonstrated a loss of normal sleep wake pattern?	☐ **Yes** ☐ **No** ☐ **N/A**
g. Does the patient currently use Continuous Positive Airway Pressure (CPAP)?	☐ **Yes** ☐ **No** ☐ **N/A**

Please add any supporting medical information that may be useful in the decision-making process:

_____

_____

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only

Document #_____

M F Rx coverage Y N

Previous Auth Y N

Coverage effective date / /

Processor Initials_____ Date_____

STANDARD - SELECT LOB_____

Approved **Reviewer Initials**_____ Date_____

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