

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Commercial Commercial Individual (PPACA) Medicaid

This request is: Urgent (life threatening) Non-Urgent (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Nuvigil[®] (armodafinil)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

Drug product: Nuvigil 50 mg tablet
 Nuvigil 150 mg tablet
 Nuvigil 200 mg tablet
 Nuvigil 250 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have one of the following diagnoses and meet any required criteria:
 - Narcolepsy
 - Confirmed by polysomnography
 - Documented therapeutic trial with one of the following: amphetamine salts, dextroamphetamine, or methylphenidate
 - Obstructive sleep apnea
 - Confirmed by polysomnography
 - Must be using CPAP for at least 2 months
 - Must be using CPAP for at least 4 hours each night
 - Shift work sleep disorder
 - Must provide documentation of a recurring work schedule that overlaps with the usual time for sleep.
2. Must have a documented therapeutic trial with modafinil (generic Provigil) with supporting documentation of failure to improve on treatment (e.g. Maintenance of Wakefulness Test (MWT) or Epworth Sleepiness Scale (ESS)).

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage.

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

Narcolepsy

1) Is the diagnosis confirmed by polysomnography? Yes No

2) Which of the following drugs has the patient tried?

- amphetamine salts
- dextroamphetamine
- methylphenidate
- None of the above

Obstructive sleep apnea

1) Is the diagnosis confirmed by polysomnography? Yes No

2) Has the patient used CPAP for at least 2 months? Yes No

3) Does the patient use CPAP 4 hours each night? Yes No

Shift work sleep disorder

1) Does the patient have a recurring work schedule that overlaps with the usual time for sleep? Yes No

Other, the patient's condition is: _____

Rationale for use: _____

B. Has the patient had a documented therapeutic trial with modafinil (generic Provigil)?

Yes

No – rationale for use: _____