pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

PROVIGIL (modafinil) / NUVIGIL (armodafinil) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Stimulants and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Preferred medication requested (clinical prior authorization required):		☐armodafinil tablet	
Non-preferred medication requested:	☐modafinil tablet	☐Nuvigil tablet	☐Provigil tablet
Strength:	Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (required):	

1. Will the beneficiary receive concurrent treatment with a sedative/hypnotic medication(s)?	☐Yes ☐No	*Submit documentation of current complete medication list.*
2. ***For non-preferred requests only***, does the beneficiary have a history of therapeutic failure (trial & failure), contraindication, or intolerance to the preferred agent, **armodafinil tablet**?	☐Yes ☐No	*Submit all supporting documentation of drug regimen and treatment outcome.*
3. ***For non-preferred requests only,*** has the beneficiary been taking the requested non-preferred medication within the past 90 days?	☐Yes ☐No	*Submit documentation of drug regimen and clinical response.*
4. ***For a diagnosis of narcolepsy***, was the beneficiary's diagnosis of narcolepsy confirmed by an overnight polysomnogram (PSG) followed by a multiple sleep latency test (MSLT)?	☐Yes ☐No	*Submit documentation of test results and differential diagnosis.*
5. ***For a diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS)***, was the beneficiary's diagnosis of OSAHS confirmed by a respiratory disturbance index (RDI) assessment of > 5 per hour?	☐Yes ☐No	*Submit documentation of test results and differential diagnosis.*
6. ***For a diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS)***, did the beneficiary try and fail continuous positive airway pressure (CPAP), while adherent to treatment, to resolve daytime sleepiness?	☐Yes ☐No	*Submit documentation of adherence to CPAP therapy and results of Epworth Sleepiness Scale assessment or MSLT.*
7. ***For a diagnosis of shift work sleep disorder (SWSD)***, does the beneficiary perform shift work that results in sleepiness on the job or insomnia at home that interferes with activities of daily living (ADL)?	☐Yes ☐No	*Submit documentation of recurring work schedule (for ≥ 1 month) and effects on ADLs.*
8. ***For a diagnosis of multiple sclerosis (MS) and fatigue associated with MS***, is the beneficiary currently receiving treatment for MS?	☐Yes ☐No	*Submit documentation of treatment regimen for MS.*
9. ***For a diagnosis of MS and fatigue associated with MS***, does the beneficiary have a history of therapeutic failure, contraindication, or intolerance to methylphenidate at maximum doses?	☐Yes ☐No	*Submit documentation of drug regimen and treatment outcome.*
10. ***For all other diagnoses,*** submit documentation of peer-reviewed medical literature or national treatment guidelines supporting the use of the requested agent for the beneficiary's diagnosis.		

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: