

PROVIGIL (modafanil) / NUVIGIL (armodafanil) PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for Provigil and Nuvigil, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Stimulants and Related Agents (accessible at:

<http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	Prescriber name:	
<input type="checkbox"/> Renewal request	# of pages in request: _____		
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested (all other stimulant requests – use “Stimulants and Related Agents Prior Authorization Form”):

modafanil tablet Nuvigil tablet Provigil tablet

Strength: Directions: Quantity: Refills:

Diagnosis: DX code (required):

ALL Provigil/Nuvigil requests:

1. Will the Recipient be receiving concurrent treatment with a sedative/hypnotic medication(s)? Yes – submit documentation of current complete medication list
 No

2. *For Nuvigil requests only:* Does the Recipient have a history of therapeutic failure (trial & failure), contraindication, or intolerance to Provigil? Yes – submit all supporting documentation of drug regimen and treatment outcome
 No

****Continue to the section that applies to the Recipient's diagnosis.****

For a diagnosis of NARCOLEPSY:

1. Has the Recipient's diagnosis of narcolepsy been confirmed by an overnight polysomnogram (PSG) followed by a multiple sleep latency test (MSLT)? Yes – submit documentation of testing and results
 No – submit documentation of differential diagnosis for narcolepsy

For a diagnosis of OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME (OSAHS):

1. Has the Recipient's diagnosis of OSAHS been confirmed by a Respiratory Disturbance Index (RDI) assessment of > 5 per hour? Yes – submit documentation of RDI assessment results
 No – submit documentation of differential diagnosis for OSAHS

2. Has the Recipient tried and failed continuous positive airway pressure (CPAP), while adherent to treatment, to resolve daytime sleepiness? Yes – submit documentation of adherence to CPAP therapy and results of Epworth Sleepiness Scale assessment or MSLT results.
 No

For a diagnosis of SHIFT WORK SLEEP DISORDER (SWSD):

1. Does the Recipient perform shift work that results in sleepiness on the job or insomnia at home that interferes with activities of daily living (ADL)? Yes – submit documentation of Recipient's recurring work schedule (for ≥ 1 month) and how the work schedule affects the Recipient's ADLs
 No

For a diagnosis of MULTIPLE SCLEROSIS AND FATIGUE ASSOCIATED WITH MULTIPLE SCLEROSIS:

1. Is the Recipient currently receiving treatment for Multiple Sclerosis (MS)? Yes – submit documentation of treatment regimen for MS
 No

2. Does the Recipient have a history of therapeutic failure, contraindication, or intolerance to methylphenidate at maximum doses? Yes – submit documentation of drug regimen and treatment outcome
 No

For ALL OTHER diagnoses:

1. Submit documentation of peer-reviewed medical literature or national treatment guidelines supporting the use of the requested agent for the Recipient's diagnosis.

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

Prescriber Signature:	Date:
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