

**STIMULANTS AND RELATED AGENTS – PROVIGIL (modafinil) / NUVIGIL (armodafinil) PRIOR AUTH FORM**

Prior authorization guidelines for **Stimulants and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:		DOB:	Phone:	Fax:

**CLINICAL INFORMATION**

<b>Drug requested:</b>	Strength:	
Directions:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):	DX code (required):	
<b><i>For a non-preferred drug:</i></b> Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred agents in this class that are FDA-approved or medically accepted for the treatment of the beneficiary's condition? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred drugs in this class.	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
Will the beneficiary receive concurrent treatment with a sedative/hypnotic medication(s)?	<input type="checkbox"/> Yes <i>Submit documentation of current complete medication list.</i> <input type="checkbox"/> No	

**Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.**

- For treatment of narcolepsy:**
  - Diagnosis was confirmed by an overnight polysomnogram (PSG) followed by a multiple sleep latency test (MSLT)
- For treatment of obstructive sleep apnea/hypopnea syndrome (OSAHS):**
  - Diagnosis was confirmed by an overnight polysomnogram (PSG) with a respiratory disturbance index of > 5 per hour
  - Tried and failed continuous positive airway pressure (CPAP) while adherent to treatment to resolve daytime sleepiness
  - Cannot use CPAP – reason: \_\_\_\_\_
  - Tried and failed an oral appliance for OSAHS to resolve daytime sleepiness
- For treatment of shift work sleep disorder (SWSD):**
  - Performs shift work that results in sleepiness on the job or insomnia at home that interferes with activities of daily living (*submit documentation of beneficiary's recurring work schedule for at least 1 month*)
- For treatment of multiple sclerosis (MS) and fatigue associated with MS:**
  - Is currently receiving treatment for MS
  - Tried and failed or cannot try methylphenidate at maximally tolerated doses
- For treatment of all other conditions:**
  - Use of the requested medication is supported by national treatment guidelines or current peer-reviewed medical literature
  - Other treatments for the condition were tried and failed or cannot be used

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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