Antinarcolepsy: Provigil, Nuvigil, Armodafinil, and Modafanil Prior Authorization Form

Member Information		
1. Member last name:		2. Member first name:
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber Information		
6. Prescribing provider NPI#:		
7. Requester contact information		
Name:		
Phone:		Ext:
Drug Information		
8. Drug name:		9. Strength:
10. Quantity per 30 days:		
11. Length of therapy (in days): ☐ up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days ☐ Other:		
Clinical Information		
1. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request. ☐ Yes ☐ No		
2. Does the member have a diagnosis of Narcolepsy? ☐ Yes ☐ No		
3. Does the member have a diagnosis of excessive sleepiness associated with shift work sleep disorder? ☐ Yes ☐ No		
4. Does the member have excessive fatigue associated with Multiple Sclerosis or Myotonic Dystonia? ☐ Yes ☐ No		
5. Does the member have a diagnosis of obstructive sleep apnea-/ hypopnea syndrome? ☐ Yes ☐ No		
6. Does the member use a CPAP? ☐ Yes ☐ No		
7. Is the member receiving ≤ 400mg of modafani or ≤ 250mg of armodafinil? ☐ Yes ☐ No		
8. If member is being prescribed a non-preferred medication, has the member tried and failed Provigil and Nuvigil? ☐ Yes ☐ No		
8b. If no, Is there a clinical reason why the member cannot use the preferred medications? ☐ Yes ☐ No		
Please explain:		
For Continuation therapy, please answer questions 1-9		
9. Has the member experienced a reduction in excessive daytime sleepiness from pre-treatment baseline as measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)? ☐ Yes ☐ No		
Signature of prescriber:		Date:
(Prescriber signature mandatory) I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.		

Fax this form to **844-376-2318**
Healthy Blue Pharmacy PA Call Center: **844-594-5072**

https://provider.healthybluenc.com

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