PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Nuvigil® (armodafinil) & Provigil® (modafinil)
Prior Authorization Request Form (Page 1 of 3)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below and complete the corresponding questions for that diagnosis:
❑ Bipolar depression (off-label) [for **Provigil (modafinil)** only]
❑ Fatigue due to multiple sclerosis (off-label) [for **Provigil (modafinil)** only]
❑ Idiopathic hypersomnia [for **Provigil (modafinil)** only]
❑ Major depressive disorder (off-label) [for **Provigil (modafinil)** only]
❑ Narcolepsy
❑ Obstructive sleep apnea/hypopnea syndrome (OSAHS)
❑ Shift work sleep disorder (SWSD)
❑ Other diagnosis:_____ICD-10 Code(s): _____

Fatigue due to multiple sclerosis [Provigil (modafinil) only]:
Is the requested medication being used in combination with standard educational therapies (e.g., psychoeducation, behavioral programs, scheduled naps, additional non-pharmacological therapies, etc.)? ❑ **Yes** ❑ **No**
If this is a reauthorization request, answer the following:
Is the patient experiencing relief of fatigue with the requested medication? ❑ **Yes** ❑ **No**
Is the requested medication still being used in combination with standard educational therapies (e.g., psychoeducation, behavioral programs, scheduled naps, additional non-pharmacological therapies, etc.)? ❑ **Yes** ❑ **No**

Idiopathic hypersomnia [Provigil (modafinil) only]:
Has the diagnosis of idiopathic hypersomnia been confirmed by a sleep study? ❑ **Yes** ❑ **No**
If a sleep study has not been completed, please justify why a sleep study was not feasible:
_____
If this is a reauthorization request, answer the following:
Is there documentation of positive clinical response to the requested medication? ❑ **Yes** ❑ **No**

Major depressive disorder or bipolar depression [Provigil (modafinil) only]:
Does the patient have a history of failure, contraindication, or intolerance to at least two antidepressants from different classes (e.g., SSRI, SNRI, bupropion)? ❑ **Yes** ❑ **No**
Is the requested medication being used as adjunctive therapy? ❑ **Yes** ❑ **No**
If this is a reauthorization request, answer the following:
Is there documentation of positive clinical response to the requested medication? ❑ **Yes** ❑ **No**
Is the requested medication being used as adjunctive therapy? ❑ **Yes** ❑ **No**

PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Nuvigil® (armodafinil) & Provigil® (modafinil) Prior Authorization Request Form (Page 2 of 3)

Narcolepsy:
Has the diagnosis of narcolepsy been confirmed by a sleep study? ❑ **Yes** ❑ **No**
If a sleep study has not been completed, please justify why a sleep study was not feasible:

_____

If this is a reauthorization request, answer the following:
Is there documentation of positive clinical response to the requested medication? ❑ **Yes** ❑ **No**

Obstructive sleep apnea/hypopnea syndrome (OSAHS):
Has the diagnosis of OSAHS been confirmed by a sleep study? ❑ **Yes** ❑ **No**
If a sleep study has not been completed, please justify why a sleep study would not be feasible:

_____

Was the diagnosis of OSAHS defined by 15 or more obstructive respiratory events (e.g., apneas, hypopneas, or respiratory effort related arousals [RERA] per hour of sleep)? ❑ **Yes** ❑ **No**
Was the diagnosis of OSAHS defined by 5 or more obstructive respiratory events (e.g., apneas, hypopneas, or respiratory effort related arousals [RERA] per hour of sleep) AND one of these symptoms (unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep)? ❑ **Yes** ❑ **No**
Have standard treatments for the underlying obstruction (e.g., continuous positive airway pressure [CPAP], bi-level positive airway pressure [BPAP], etc.) been used for 3 months or longer? ❑ **Yes** ❑ **No**
Is the patient fully compliant on standard treatments for the underlying obstruction? ❑ **Yes** ❑ **No**
If this is a reauthorization request, answer the following:
Does the patient continue to be fully compliant on concurrent standard treatments (e.g., CPAP, BPAP, etc.) for the underlying obstruction? ❑ **Yes** ❑ **No**
Is the patient experiencing relief of symptomatic hypersomnolence with use of the requested medication? ❑ **Yes** ❑ **No**

Shift work sleep disorder (SWSD):
Has SWSD been confirmed by one of the following (select from the two options below)?
❑ Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase
❑ Sleep study demonstrating loss of a normal sleep-wake pattern (i.e., disturbed chronobiologic rhythmicity)
Does the patient's sleep disturbance cause significant distress or significant impairment in occupational functioning? ❑ **Yes** ❑ **No**
Has it been confirmed that no other medical or mental disorder (e.g., depression) accounted for the symptoms? ❑ **Yes** ❑ **No**
Has it been confirmed that symptoms did not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g., jet lag syndrome)? ❑ **Yes** ❑ **No**
If this is a reauthorization request, answer the following:
Is the patient experiencing relief with use of the requested medication of excessive sleepiness or insomnia associated with a work period (usually night work) that occurs during the habitual sleep phase? ❑ **Yes** ❑ **No**
Does the patient's sleep disturbance continue to cause clinically significant distress or significant impairment in occupational functioning? ❑ **Yes** ❑ **No**
Does the patient still require treatment for SWSD? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____
Also answer the following:
Does the patient have a history of inadequate response to Provigil (modafinil) 200mg/day? ❑ **Yes** ❑ **No**

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Nuvigil® (armodafinil) & Provigil® (modafinil) Prior Authorization Request Form (Page 3 of 3)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	