AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Armodafinil, Modafinil, Nuvigil, Provigil

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___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 beneficiary have a diagnosis of Narcolepsy? Yes___ No___
3. Does the beneficiary have a diagnosis of excessive sleepiness associated with shift work sleep disorder? Yes___ No___
4. Does the beneficiary have excessive fatigue associated with Multiple Sclerosis or Myotonic Dystonia? Yes___ No___
5. Does the beneficiary have a diagnosis of obstructive sleep apnea-/hypopnea syndrome? Yes___ No___
6. Does the beneficiary use a CPAP? Yes___ No___
7. Is the beneficiary receiving $\leq$ 400mg of modafinil or $\leq$ 250mg of armodafinil? Yes___ No___
8. If beneficiary is being prescribed a non-preferred medication, has the beneficiary tried and failed Provigil and Nuvigil? Yes___ No___
   8a. If no, Is there a clinical reason why the beneficiary cannot use the preferred medications? Yes___ No___
   Please explain: _____

For Continuation therapy, please answer questions 1-9

9. Has the beneficiary 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406