carolina complete health™

Pharmacy Prior Approval Request for Antinarcolepsy: Provigil, Nuvigil, Armodafinil, and Modafanil

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____

3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary 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 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 ≤ 400mg of modafani or ≤ 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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/