MedStar Medicare Choice

MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
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ARMODAFINIL (NUVIGIL)
Prior Authorization Form

☐ Standard Request (72 hours) ☐ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Armodafinil	☐50mg Tablet ☐100mg Tablet ☐200mg Tablet ☐250mg Tablet			
☐ New medication ☐ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Clinical Information

For all indications, has the patient had an adequate trial of modafinil (required for coverage)? ☐ Yes ☐ No

Please provide dates of therapy, maximum dose, and reason for discontinuation of modafinil?

☐ Narcolepsy	Please provide chart documentation of a sleep study Has patient tried and failed a CNS stimulant (such as methylphenidate, amphetamine salts, dextroamphetamine)? ☐ Yes ☐ No Please provide dates of therapy, maximum dose, and reason for discontinuation of stimulants?
☐ Obstructive sleep apnea	Please provide chart documentation of a sleep study and compliance with use of a CPAP machine.
☐ Shift work sleep disorder	Are there any other medical or mental disorders that account for the symptoms? ☐ Yes ☐ No Please indicate number of over-night shifts worked per month:____________________ ☐ Please provide chart documentation of the shift work schedule. ☐ Please provide chart documentation of a sleep study.
☐ Other	Diagnosis:____________________________________ Date Diagnosed:____________

Please provide any additional information which should be considered in the space below:

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