OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Nuvigil® (armodafinil) & Provigil® (modafinil) Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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 [for **Provigil (modafinil)** only]
- ❑ Fatigue due to multiple sclerosis [for **Provigil (modafinil)** only]
- ❑ Major depressive disorder [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**

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**

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**

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

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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 per hour of sleep)? ❑ **Yes** ❑ **No**
Was the diagnosis of OSAHS defined by 5 or more obstructive respiratory events 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):
Select If SWSD has been confirmed by one of the following:
❑ 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 clinically significant distress or significant impairment in occupational functioning? ❑ **Yes** ❑ **No**
Has it been confirmed that no other medical, mental health, or sleep disorder accounts for the symptoms producing insomnia or excessive sleepiness? ❑ **Yes** ❑ **No**
If this is a reauthorization request, answer the following:
Is there documentation of positive clinical response to the requested medication? ❑ **Yes** ❑ **No**
Does the patient still require treatment for SWSD (i.e., sleep disturbance continues to cause significant distress or impairment in occupational functioning)? ❑ **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**

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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.