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) 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:

❑ Narcolepsy
❑ Obstructive sleep apnea/hypopnea syndrome (OSAHS)
❑ Shift work sleep disorder (SWSD)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Narcolepsy:

Has the diagnosis of narcolepsy been confirmed by a sleep study? ❑ **Yes** ❑ **No**

If a sleep study has not been completed, please provide justification confirming why a sleep study would not be feasible:

_____

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Amphetamine
❑ Amphetamine-dextroamphetamine
❑ Armodafinil
❑ Dexedrine
❑ Dextroamphetamine
❑ Dextroamphetamine extended-release (ER)
❑ Evekeo
❑ Metadate ER
❑ Methylin
❑ Methylphenidate (generic Ritalin)
❑ Methylphenidate chewable tablet
❑ Methylphenidate ER (10mg, 20mg tablets)
❑ Methylphenidate ER (18mg, 27mg, 36mg, 54mg, 72mg tablets)
❑ Methylphenidate solution
❑ Modafinil
❑ Procentra
❑ Ritalin
❑ Zenzedi

Reauthorization:
If this is a reauthorization request, answer the following:
Is there documentation of positive clinical response to prior therapy? ❑ **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 provide justification confirming 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**

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Armodafinil
❑ Modafinil

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

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

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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 associated with a work period (usually night work) that occurs during the normal sleep period.
- ❑ Sleep study demonstrating loss of a normal sleep-wake pattern (i.e., disturbed chronobiologic rhythmicity).

Has it been confirmed that no other medical condition or medication accounts for the symptoms? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Armodafinil ❑ Modafinil

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation of positive clinical response to therapy? ❑ **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
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.