12/22/2012

Prior Authorization Form

AETNA ARIZONA MERCY CARE PLAN (MEDICAID)

Nuvigil (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to Mercy Care Plan at **1-800-854-7614**.

Please contact Mercy Care Plan at **1-800-624-3879** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Nuvigil (Medicaid).

Drug Name (select from list of drugs shown)

Nuvigil (armodafinil)

Patient Information

Patient Name: ______________________

Patient ID: ______________________

Patient Group No.: ______________________

Patient DOB: ______________________

Patient Phone:

Prescribing Physician

Physician Name: ______________________

Physician Phone: ______________________

Physician Fax: ______________________

Physician Address: ______________________

City, State, Zip: ______________________

Diagnosis: ______________________ **ICD Code:** ______________________

Please circle the appropriate answer for each question.

1. Is this a renewal request? Y N

   [If the answer to this question is no, then skip to question 3.]

2. Is the patient having a response to treatment? Y N

   [No further questions required.]

3. Does the patient have a diagnosis of Narcolepsy? Y N

   [If the answer to this question is no, then skip to question 5.]

4. Has the patient had a trial and failure of, or documented contraindication to formulary CNS stimulants (e.g., amphetamine salts, methylphenidate)? If yes, please document medication(s) tried and reason for treatment failure: Y N ______________________

   [No further questions required.]

5. Does the patient have a diagnosis of Obstructive Sleep Apnea? Y N

   [If the answer to this question is no, then skip to question 7.]

6. Has the patient had a trial and failure of, or Obstructive Sleep Apnea continues despite use of CPAP? Y N

   [No further questions required.]

7. Does the patient have a diagnosis of Circadian rhythm disruption (i.e., shift-work sleep disorder)? Y N

   [If the answer to this question is yes, then no further questions required.]

8. Does the patient have a diagnosis of Cancer-related fatigue? Y N

   [If the answer to this question is yes, then skip to question 10.]

9. Does the patient have a diagnosis of Fatigue due to Multiple Sclerosis (MS)? Y N

   [If the answer to this question is no, then skip to question 11.]

10. Has the patient had a trial and failure of methylphenidate? Y N

   [No further questions required.]

11. Does the patient have a diagnosis of Idiopathic hypersomnia? Y N

12. Has the patient had a trial and failure of 2 formulary stimulants (e.g., amphetamine salts, methylphenidate)? If yes, please document medication(s) tried and reason for treatment failure: Y N ____________________

Comments: ____

I affirm that the information given on this form is true and accurate as of this date.

____

Prescriber (Or Authorized) Signature and Date