US Family Health Plan Prior Authorization Request
Form for **Nuvigil** (armodafinil)

5599

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan pharmacy program (USFHP).

MAIL ORDER and RETAIL	• The provider may **call**: **1-877-880-7007** or the completed form may be **faxed** to:**1-617-562-5296** • The patient may attach the completed form to the prescription and mail it to: ATTN: Pharmacy, 77 Warren St, Brighton, MA 02135

Prior authorization criteria and a copy of this form are available at:http://usfamilyhealth.org/for-providers/downloadable-forms.
This prior authorization is effective for 1 year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. What is the indication or diagnosis? Document the indication or diagnosis and **proceed to Question 2**		
2. Has the patient tried modafinil (Provigil)?	☐ Yes Proceed to question 3	☐ No **Coverage not approved**
3. Does the patient meet BOTH of the following criteria? • A diagnosis of excessive daytime sleepiness associated with **narcolepsy**. • Narcolepsy was diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing.	☐ Yes **Sign and date below**	☐ No **Proceed to question 4**
4. Does the patient meet BOTH of the following criteria? • Excessive daytime sleepiness associated with **obstructive sleep apnea/hypopnea syndrome (OSAHS)**. • The patient has had adequate titration of continuous positive airway pressure (CPAP) treatment.	☐ Yes **Sign and date below**	☐ No **Proceed to question 5**
5. Does the patient meet BOTH of the following criteria? • Excessive sleepiness associated with **shift-worker sleep disorder (SWSD)**. •The patient works night shifts.	☐ Yes **Sign and date below**	☐ No **Coverage not approved** †

† Coverage is NOT provided for the treatment of other conditions not listed above, including: jet lag, excessive fatigue associated with multiple sclerosis, excessive fatigue associated with myotonic dystrophy, depression, idiopathic hypersomnia, fatigue associated with traumatic brain injury, chronic fatigue syndrome, stroke rehabilitation, appetite suppression, Parkinson's disease.

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

_____ _____
Prescriber Signature Date

11 July 2012