

# Armodafinil (Nuvigil) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the US Family Health Plan or the US Family Health Plan Pharmacy Program.

<b>MAIL ORDER</b>	<p>If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/></p>	<b>RETAIL</b>	<p>If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/></p>
	<p>The completed form and the prescription may be faxed to 1-617-562-5296</p> <p>OR</p> <p>The patient may attach the completed form to the prescription and mail it to:                  US Family Health Plan                  Attn: Pharmacy,                  77 Warren Street                  Brighton, MA 02135</p>		<p>The provider may call: 1-877-880-7007</p> <p>OR</p> <p>The completed form may be faxed to 1-617-562-5296</p>

**Drug for which Prior Authorization is requested: Armodafinil (Nuvigil)**

<b>Step 1</b>	<p><b>Please complete patient and physician information (Please Print)</b></p> <p>Patient Name: _____ Physician Name: _____</p> <p>Address: _____ Address: _____</p> <p>Sponsor ID# _____ Phone #: _____</p> <p>Date of Birth: _____ Secure Fax #: _____</p>											
<b>Step 2</b>	<p><b>Please complete the clinical assessment</b></p> <table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"> <p>1. Does the patient have a diagnosis of narcolepsy associated with persistent and excessive daytime sleepiness as diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing?</p> </td> <td style="width: 25%;"> <p><input type="checkbox"/> <b>Yes</b> Please sign and date.</p> </td> <td style="width: 25%;"> <p><input type="checkbox"/> <b>No</b> Please proceed to Question 2</p> </td> </tr> <tr> <td> <p>2. Does the patient meet BOTH of the following criteria?                      • A diagnosis of obstructive sleep apnea associated with persistent and excessive daytime sleepiness                      • Continuous positive airway pressure (CPAP) treatment has been adequately titrated and the patient is compliant with treatment</p> </td> <td> <p><input type="checkbox"/> <b>Yes</b> Please sign and date.</p> </td> <td> <p><input type="checkbox"/> <b>No</b> Please proceed to Question 3</p> </td> </tr> <tr> <td> <p>3. Is the patient a nightshift worker with a diagnosis of shift-worker sleep disorder (SWSD) associated with excessive sleepiness?</p> </td> <td> <p><input type="checkbox"/> <b>Yes</b> Please sign and date.</p> </td> <td> <p><input type="checkbox"/> <b>No</b> Coverage not approved</p> </td> </tr> </table>			<p>1. Does the patient have a diagnosis of narcolepsy associated with persistent and excessive daytime sleepiness as diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing?</p>	<p><input type="checkbox"/> <b>Yes</b> Please sign and date.</p>	<p><input type="checkbox"/> <b>No</b> Please proceed to Question 2</p>	<p>2. Does the patient meet BOTH of the following criteria?                      • A diagnosis of obstructive sleep apnea associated with persistent and excessive daytime sleepiness                      • Continuous positive airway pressure (CPAP) treatment has been adequately titrated and the patient is compliant with treatment</p>	<p><input type="checkbox"/> <b>Yes</b> Please sign and date.</p>	<p><input type="checkbox"/> <b>No</b> Please proceed to Question 3</p>	<p>3. Is the patient a nightshift worker with a diagnosis of shift-worker sleep disorder (SWSD) associated with excessive sleepiness?</p>	<p><input type="checkbox"/> <b>Yes</b> Please sign and date.</p>	<p><input type="checkbox"/> <b>No</b> Coverage not approved</p>
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<b>Step 3</b>	<p><b>I certify that the above is correct to the best of my knowledge (Please sign and date):</b></p> <p>_____</p> <p style="display: flex; justify-content: space-between;"><span><b>Prescriber Signature</b></span><span><b>Date</b></span></p>											