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Armodafinil & Modafinil Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)	
1. Is the patient using the requested drug for fatigue related to multiple sclerosis?	❑ Yes ❑ No
2. Does the patient have a diagnosis of narcolepsy confirmed by sleep lab evaluation?	❑ Yes ❑ No
3. Does the patient have a diagnosis of Shift Work Disorder (SWD) **and** does patient experience excessive sleepiness while working?	❑ Yes ❑ No
4. Does the patient have a diagnosis of obstructive sleep apnea (OSA) confirmed by polysomnography?	❑ Yes ❑ No
5. Is the patient currently utilizing continuous positive airway pressure (CPAP) therapy **or** is CPAP therapy contraindicated or ineffective for the patient?	❑ Yes ❑ No
6. Does the patient have mild to moderate obstructive sleep apnea **and** is compliant with oral appliance use?	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

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 more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern