



Please complete ALL information below and fax your request to 1-888-671-5285

Nuvigil® (armodafinil) Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Narcolepsy	
<input type="checkbox"/> Obstructive sleep apnea/hypopnea syndrome (OSAHS)	
<input type="checkbox"/> Shift Work Sleep Disorder (SWSD)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Narcolepsy:	
Was the requested medication recommended by a neurologist or sleep specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the diagnosis confirmed by one of the following tests: Polysomnography (PSG) or Multiple sleep latency test (MSLT)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Obstructive sleep apnea/hypopnea syndrome (OSAHS):	
Was the patient diagnosed by a sleep specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the requested medication being used as an adjunct to standard therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Shift Work Sleep Disorder (SWSD):	
Was the requested medication recommended by a neurologist or sleep specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there documentation that polysomnography and the multiple sleep latency test (MSLT) demonstrate loss of a normal sleep-wake pattern? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Can the symptoms be attributed to a medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do the symptoms meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g., time-zone change [jet lag] syndrome)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For brand Nuvigil, also answer the following:	
Has the patient had an inadequate response to or inability to tolerate generic modafinil or armodafinil? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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.

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