FUTURE SCRIPTS

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

Armodafinil Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Narcolepsy
- ❑ Obstructive sleep apnea/hypopnea syndrome (OSAHS)
- ❑ Shift Work Sleep Disorder (SWSD)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Narcolepsy:

Was the requested medication recommended by a neurologist or sleep specialist? ❑ **Yes** ❑ **No**

Obstructive sleep apnea/hypopnea syndrome (OSAHS):

Was the patient diagnosed by a sleep specialist? ❑ **Yes** ❑ **No**

Is the requested medication being used as an adjunct to standard therapy? ❑ **Yes** ❑ **No**

Shift Work Sleep Disorder (SWSD):

Was the requested medication recommended by a neurologist or sleep specialist? ❑ **Yes** ❑ **No**

Did the patient have a polysomnography and the multiple sleep latency test (MSLT) demonstrated loss of a normal sleep-wake pattern? ❑ **Yes** ❑ **No**

Can the symptoms be attributed to a medical condition? ❑ **Yes** ❑ **No**

Do the symptoms meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g., time-zone change [jet lag] syndrome)? ❑ **Yes** ❑ **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.