

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

NUVIGIL (armodafinil)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL
NECESSITY TO 855-828-4992**

CRITERIA:

- Failure on a ≥ 6 week trial of, or contraindication to, modafinil (Provigil)
- Minimum age requirement: 17 years old
- Covered for diagnosis:
 - Narcolepsy- Amphetamines or Methylphenidate must be tried first. Dose limited to 250mg qd.
 - Daytime somnolence due to Obstructive sleep apnea, **must be on C-pap**. Dose limited to 150mg qd.
 - Shift Work Sleep Disorder, **must be working night shifts**. Provide documentation of a treatment plan that demonstrates excessive sleepiness at work, insomnia when the patient should be sleeping. Patient must have a three month trial of sleep aids. Dose limited to 150mg/day.

NOTES:

Modafinil (Provigil) and Nuvigil are mutually exclusive. Patients may only have a prior authorization for one of these medications at a time.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

10/11/2012

<https://medicaid.utah.gov/pharmacy/>