Analeptic Prior Authorization Form

(Modafinil, Armodafinil, Pitolisant, Solriamfetol, etc)

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID # | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (Credentials)

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI # | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

Pharmacy 10-Digit NPI # | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name | Strength | Duration (if applicable) | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

Please document all other medications previously attempted for the treatment of the patient's condition. Please include the medication names, strengths, directions, start dates, end dates, and reasons for discontinuing each trial.

Please choose and complete **only one** of the following five diagnosis areas:

Diagnosis: Narcolepsy

Has the patient completed a polysomnogram (PSG) and multiple sleep latency test (MSLT) conducted by a sleep specialist physician? ☐ Yes (please attach sleep study reports) ☐ No (not approved)

Updated 8/15/2025

Diagnosis: Obstructive Sleep Apnea

Has the patient completed a PSG conducted by a sleep specialist physician?	☐ Yes (please attach sleep study report)	☐ No (not approved)
Does the patient qualify for, currently use, and comply with using a sleep apnea positive airway pressure device (e.g., CPAP, BiPAP)?	☐ Yes	☐ No (not approved)
What is the patient's Epworth Sleepiness Scale (ESS) score?		Date Assessed:
Is the patient taking other sedating medications that cannot be discontinued?	☐ Yes (please explain below)	☐ No

Diagnosis: Multiple Sclerosis Fatigue

What is the patient's Multiple Sclerosis Fatigue Severity Scale (FSS) score?		Date Assessed:
Is the patient taking other sedating medications that cannot be discontinued?	☐ Yes (please explain below)	☐ No

Diagnosis: Shift Work Disorder

Does the patient's condition interfere with employment that requires shift work?	☐ Yes	☐ No (not approved)
What is the patient's ESS score?		Date Assessed:
Please describe the patient's employment and the typical shift work schedule the patient works.		

Diagnosis: Idiopathic Hypersomnia

Has the patient completed a PSG and MSLT conducted by a sleep specialist physician?	☐ Yes (please attach sleep study reports)	☐ No (not approved)

Attestation: Your signature (manual or electronic) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)