Provigil®/Nuvigil® Prior Authorization Form
(modafinil/armodafinil)

West Virginia Medicaid
Drug Prior Authorization Form
http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

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)	(MI)	WV Medicaid 11-Digit ID #	Date of Birth (MM/DD/YYYY)

Prescriber Name (Last)	(First)	(MI)

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

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

Pharmacy Name (if applicable)

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

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.

☐ Provigil®	☐ Nuvigil®	Strength	Route of Administration
Directions		Diagnosis	ICD Diagnosis Code (if available)

Please choose only one of the four following diagnosis areas:

Diagnosis: Multiple Sclerosis Fatigue:

1. Is the patient greater than 16 years of age?	☐ Yes	☐ No (not approved)
2. What is the patient's Multiple Sclerosis Fatigue Severity Scale score? (submit form found with criteria)		
3. Did the patient have unsatisfactory outcomes from a trial of a preferred stimulant?	☐ Yes (explain)	☐ No (explain)

Diagnosis: Narcolepsy:

1. Is the patient greater than 16 years of age?	☐ Yes	☐ No (not approved)
2. Has the patient completed a sleep study conducted by a sleep specialist physician?	☐ Yes (submit sleep study report)	☐ No (not approved)

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Diagnosis: Sleep Apnea/Hypopnea Syndrome:

1. Is the patient greater than 16 years of age?	☐ Yes	☐ No (not approved)
2. Has the patient completed a sleep study conducted by a sleep specialist physician?	☐ Yes (submit sleep study report)	☐ No (not approved)
3. What is the patient's Epworth Daytime Sleepiness Scale score? (submit form found with criteria)		
4. Is the patient taking other sedating medications that cannot be discontinued?	☐ Yes (explain)	☐ No
5. Does the patient qualify for, currently use, and comply with using a sleep apnea positive air pressure device (CPAP, BiPAP)?	☐ Yes	☐ No (explain)

Shift Work:

1. Is the patient greater than 16 years of age?	☐ Yes	☐ No (not approved)
2. Does the patient's condition interfere with employment that requires shift work?	☐ Yes (explain)	☐ No
3. What is the patient's Epworth Daytime Sleepiness Scale score? (submit form found with criteria)		

Other Pertinent Information (attach additional pages)

Attestation: Your signature (manually or electronically) 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)