CAREFIRST
Nuvigil

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Nuvigil.

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (specify drug)

_____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Does the patient have a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)?	**Y** ☐	**N** ☐
2.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
3.	Has the patient achieved or maintained a positive response to treatment from baseline?	**Y** ☐	**N** ☐
4.	Is the patient compliant with using continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP)?	**Y** ☐	**N** ☐
5.	Is the requested drug being prescribed by, or in consultation with, a sleep specialist?	**Y** ☐	**N** ☐
6.	Is the diagnosis confirmed by polysomnography or home sleep apnea test (HSAT) with a technically adequate device?	**Y** ☐	**N** ☐
7.	Has the patient been receiving treatment for the underlying airway obstruction (continuous positive airway pressure [CPAP] or bilevel positive airway pressure [BIPAP]) for at least one month?	**Y** ☐	**N** ☐
8.	Will the patient continue to use continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) after the requested drug is started?	**Y** ☐	**N** ☐
9.	Does the patient have a diagnosis of excessive sleepiness associated with narcolepsy?	**Y** ☐	**N** ☐
10.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
11.	Has the patient achieved or maintained a positive response to treatment from baseline?	**Y** ☐	**N** ☐
12.	Is the requested drug being prescribed by, or in consultation with, a sleep specialist?	**Y** ☐	**N** ☐
13.	Is the diagnosis confirmed by a sleep study?	**Y** ☐	**N** ☐

14.	Does the patient have a diagnosis of excessive sleepiness associated with Shift Work Disorder (SWD)?	**Y** ☐	**N** ☐
15.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
16.	Has the patient achieved or maintained a positive response to treatment from baseline?	**Y** ☐	**N** ☐
17.	Is the patient still a shift-worker?	**Y** ☐	**N** ☐
18.	Is the requested drug being prescribed by, or in consultation with, a sleep specialist?	**Y** ☐	**N** ☐
19.	Has a sleep log and actigraphy monitoring been completed for at least 14 days and shows a disrupted sleep and wake pattern?	**Y** ☐	**N** ☐
20.	Have the patient's symptoms been present for 3 or more months?	**Y** ☐	**N** ☐
21.	Does the patient require MORE than the plan allowance per month of any of the following: A) 60 tablets of armodafinil (Nuvigil) 50 mg, B) 30 tablets of armodafinil (Nuvigil) 150 mg, 200 mg, 250 mg?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date