PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
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. What is the diagnosis?
   - Excessive daytime sleepiness (EDS) with narcolepsy (If checked, go to 2) ☐
   - Cataplexy with narcolepsy (If checked, go to 11) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the requested drug prescribed by, or in consultation with, a sleep specialist (e.g., neurologist experienced with sleep disorders, physician certified in sleep medicine)? **Y** ☐ **N** ☐

3. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

4. Has the patient demonstrated a beneficial response to treatment with the requested drug defined by a decrease in symptoms of daytime sleepiness from baseline? ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical record documentation. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Has the diagnosis of narcolepsy been confirmed by a sleep lab evaluation? ACTION REQUIRED: If Yes, attach supporting chart note(s). **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

6. What is the patient's age?
   - Less than 6 years old (If checked, no further questions) ☐
   - 6 years to less than 18 years old (If checked, go to 7) ☐
   - 18 years old or older (If checked, go to 9) ☐

7. Has the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate)? ACTION REQUIRED: If Yes, attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

8. Does the patient have a contraindication to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate)? ACTION REQUIRED: If Yes, attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9.	Has the patient experienced an inadequate treatment response or intolerance to armodafinil or modafinil? ACTION REQUIRED: If Yes, attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
10.	Does the patient have a contraindication to both armodafinil AND modafinil? ACTION REQUIRED: If Yes, attach documentation of clinical reason to avoid therapy. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
11.	Is the requested drug prescribed by, or in consultation with, a sleep specialist (e.g., neurologist experienced with sleep disorders, physician certified in sleep medicine)?	**Y** ☐	**N** ☐
12.	Is the patient currently receiving treatment with the requested medication?	**Y** ☐	**N** ☐
13.	Has the patient demonstrated a beneficial response to treatment with the requested drug defined by a decrease in cataplexy episodes from baseline? ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical record documentation. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
14.	Is the patient an adult?	**Y** ☐	**N** ☐
15.	Has the diagnosis of narcolepsy been confirmed by a sleep lab evaluation? ACTION REQUIRED: If Yes, attach supporting chart note(s). ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
16.	Does the patient experience at least 3 cataplexy attacks per week?	**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