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:** 6/24/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
_
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?
   - Cataplexy with narcolepsy (If checked, go to 2) ☐
   - Excessive daytime sleepiness (EDS) with narcolepsy (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Will the requested drug be 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 drug? **Y** ☐ **N** ☐
4. What is the diagnosis?
   - Cataplexy with narcolepsy (If checked, go to 5) ☐
   - Excessive daytime sleepiness (EDS) with narcolepsy (If checked, go to 6) ☐
5. Has the patient demonstrated a beneficial response to treatment as defined by a decrease in cataplexy episodes from baseline? ACTION REQUIRED: If Yes, attach supporting chart notes or medical record documentation. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
6. Has the patient demonstrated a beneficial response to treatment as defined by a decrease in daytime sleepiness with narcolepsy from baseline? ACTION REQUIRED: If Yes, attach supporting chart notes or medical record documentation. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
7. What is the diagnosis?
   - Cataplexy with narcolepsy (If checked, go to 8) ☐
   - Excessive daytime sleepiness (EDS) with narcolepsy (If checked, go to 11) ☐
8. Is the patient 7 years of age or older? **Y** ☐ **N** ☐
9. Has the diagnosis of narcolepsy been confirmed by a sleep lab evaluation? ACTION REQUIRED: If Yes, attach supporting documentation **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
10. Does the patient have a baseline history of at least 3 cataplexy attacks per week? **Y** ☐ **N** ☐

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

12. What is the patient's age?
    - Less than 7 years old (If checked, no further questions) ☐
    - 7 years to less than 18 years old (If checked, go to 15) ☐
    - Greater than or equal to 18 years old (If checked, go to 13) ☐

13. Has the patient experienced an inadequate response or intolerance to armodafinil or modafinil? ACTION REQUIRED: If Yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

14. Does the patient have a contraindication to both armodafinil AND modafinil? ACTION REQUIRED: If Yes, attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

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

16. 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

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