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) ☐
   - Idiopathic hypersomnia (IH) (If checked, go to 2) ☐
   - 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. What is the diagnosis?
   - Cataplexy with narcolepsy (If checked, go to 5) ☐
   - Excessive daytime sleepiness (EDS) with narcolepsy (If checked, go to 6) ☐
   - Idiopathic hypersomnia (IH) (If checked, go to 7) ☐

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 note(s) 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 note(s) or medical record documentation. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

7. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐

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

9. What is the diagnosis?
   - Cataplexy with narcolepsy (If checked, go to 10) ☐

Excessive daytime sleepiness (EDS) with narcolepsy (If checked, go to 13) ☐

Idiopathic hypersomnia (IH) (If checked, go to 19) ☐

10. Is the patient 7 years of age or older? **Y** ☐ **N** ☐

11. Has a 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** ☐

12. Does the patient experience at least 3 cataplexy attacks per week? **Y** ☐ **N** ☐

13. Has a 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** ☐

14. 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 17) ☐

Greater than or equal to 18 years old (If checked, go to 15) ☐

15. 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** ☐

16. 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** ☐

17. 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.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

18. 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.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

19. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐

20. Has there been a presence of daytime lapses into sleep or daily irrepressible periods of need to sleep for at least 3 months? **Y** ☐ **N** ☐

21. Has insufficient sleep syndrome been ruled out such as by lack of improvement in sleepiness after an adequate trial of increased nocturnal time in bed, preferably confirmed by at least a week of sleep log with wrist actigraphy? **Y** ☐ **N** ☐

22. Has a multiple sleep latency test (MSLT) documented fewer than two sleep onset rapid eye movement periods (SOREMPs)? ACTION REQUIRED: If Yes, attach supporting chart note(s).
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

23. Has a multiple sleep latency test (MSLT) documented no sleep onset rapid eye movement periods (SOREMPs) if the rapid eye movement (REM) latency on the preceding polysomnogram was less than or equal to 15 minutes? ACTION REQUIRED: If Yes, attach supporting chart note(s).
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

24. Does the patient have a mean sleep latency on multiple sleep latency test (MSLT) of less than or equal to 8 minutes? ACTION REQUIRIED: If Yes, attach supporting chart note(s).
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

25. Does the patient have a total 24-hour sleep time of greater than or equal to 660 minutes on 24-hour polysomnographic monitoring after correcting any chronic sleep deprivation or by wrist actigraphy in association with a sleep log and averaged over at least 7 days of unrestricted sleep? ACTION REQUIRED: If Yes, attach supporting chart note(s).
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

26. Can the hypersomnolence or multiple sleep latency test (MSLT) results be better explained by another sleep disorder, other medical or psychiatric disorder, or use or withdrawal of drugs or medications? **Y** ☐ **N** ☐

27. Does the patient have cataplexy? **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