

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay the authorization process.*

Drug Requested (please select applicable drug below): (Non-Preferred) **(MEDICAID)**

Nuvigil® (armodafinil)

Provigil® (modafinil)

modafinil (generic)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Name/Form: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Length of Authorization: Sleep Apnea and Narcolepsy – 1 year; Shift Work Sleep Disorder – 6 months

CLINICAL CRITERIA: Check applicable box(es) below that apply. If not checked, authorization process will be delayed.

- Patient has one of the following diagnoses: (*check ONE indication and corresponding criteria*)
- Sleep Apnea:** Documentation/confirmation via sleep study or that C-PAP has been maximized;
OR
 - Narcolepsy:** documentation of diagnosis via sleep study;
 - Diagnosed by a polysomnogram or mean sleep latency time (MSLT) test – **results must be attached****OR**
 - Shift-Work Sleep Disorder:** **ONLY APPROVABLE FOR 6 MONTHS**; work schedule **must** be verified and documented. (*Shift work is defined as working the all night shift.*)
AND
- Patient's age must be as followed:
- Nuvigil® - age is > 17 years
 - Provigil® - age is >16 years

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____