# OPTIMA HEALTH COMMUNITY CARE
# AND
# OPTIMA FAMILY CARE
# (MEDICAID)

## 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)** |
|---|---|---|
| ❑ **Nuvigil®** (armodafinil) | ❑ **Provigil®** (modafinil) | ❑ modafinil (generic) |

**DRUG INFORMATION**: Complete information below or 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 to ensure authorization will NOT 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

**(Continued on next page; signature page MUST be included with this request.)**

**(Signature page MUST be attached to this request.)**

***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 #:** _____

**REVISED/UPDATED:** ~~6/29/2017;~~ ~~8/31/2017;~~ **8/28/2018**