OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 #: _____

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