

OPTIMA HEALTH PLAN

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 authorization process.

Drug Requested: **Provigil® (modafinil)**

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: ALL appropriate boxes **must** be checked to qualify. Chart notes and/or lab results **MUST** be attached to this request. If incomplete, authorization process will be delayed.

- Patient is at least 16 years old

AND

- Patient has **one** of the following diagnoses: (**check one indication and corresponding criteria**)
- Narcolepsy with excessive daytime sleepiness
 - Diagnosed by a polysomnogram or mean sleep latency time (MSLT) test – **results must be attached**
 - Obstructive Sleep Apnea with excessive daytime sleepiness
 - Diagnosed by polysomnography with respiratory monitoring – **results must be attached**
 - Current CPAP therapy that has been adequately titrated and the member is compliant with
 - Shift-Work Sleep Disorder
 - Parkinson's disease with excessive fatigue
 - Myotonic dystrophy with excessive fatigue

NOTE: The concomitant use of Provigil® with other CNS Stimulant medication (e.g. amphetamine salts, methylphenidate) will not be covered.

****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 #: _____

*Approved by Pharmacy & Therapeutics Committee: 11/18/2008

REVISED/UPDATED: 6/4/2011; 8/30/11; 9/14/11; 4/14/2014; 11/2/2014; 3/19/2015; 4/29/2015; 5/27/2015; 12/23/2015; 12/19/2016; 9/22/2017