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: ~~6/1/2011; 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;~~ **8/20/2017**