

Armodafinil Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
Select the diagnosis below: <input type="checkbox"/> Narcolepsy w ith excessive daytime sleepiness <input type="checkbox"/> Obstructive sleep apnea w ith excessive daytime sleepiness <input type="checkbox"/> Shift-w ork sleep disorder <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Narcolepsy with excessive daytime sleepiness: Was narcolepsy w ith excessive daytime sleepiness diagnosed by a polysomnogram or mean sleep latency time (MSLT) test? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Results must be attached</i>					
Obstructive sleep apnea with excessive daytime sleepiness: Was obstructive sleep apnea w ith excessive daytime sleepiness diagnosed by polysomnography w ith respiratory monitoring? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Results must be attached</i> Is the patient currently on and compliant w ith CPAP therapy that has been adequately titrated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity limit requests: What is the quantity requested per DAY? _____ Previous therapies failed and/or therapies currently used in combination w ith the requested medication (<i>List ALL medications tried or authorization process will be delayed</i>): _____ _____ _____ Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature). ** Please note: Chart documentation of the above is required to be submitted along with this fax _____ _____					
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.*					
Prescriber Signature: _____			Date: _____		

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Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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