



Prescriber Information

<p>Last Name:</p> <input style="width: 100%; height: 20px;" type="text"/> <p>DEA/NPI:</p> <input style="width: 100%; height: 20px;" type="text"/> <p>Phone</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>First Name</p> <input style="width: 100%; height: 20px;" type="text"/> <p>Specialty:</p> <input style="width: 100%; height: 20px;" type="text"/> <p>Fax</p> <input style="width: 100%; height: 20px;" type="text"/>
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Member Information

<p>Last Name:</p> <input style="width: 100%; height: 20px;" type="text"/> <p>Member ID Number</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>First Name</p> <input style="width: 100%; height: 20px;" type="text"/> <p>DOB:</p> <input style="width: 100%; height: 20px;" type="text"/>
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Medication Information:

<p>Drug Name and Strength:</p> <hr/> <p>Diagnosis:</p> <hr/>	<p>Quantity and Dosing:</p> <hr/> <p>Duration:</p> <hr/>
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Modafinil Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient

1. What is the patient's diagnosis? **(Please circle)**

- A. Narcolepsy **(go to Section 1)**
- B. Obstructive Sleep Apnea-Hypopnea Syndrome **(go to Section 2)**
- C. Shift-work Sleep Disorder (SWSD) **(go to Section 3)**
- D. Other: **(please document and stop)** _____

Section 1: Narcolepsy

2. Has the patient received a Multiple Sleep Latency Test (MSLT) and the patient has a mean sleep latency of less than 10 minutes with documented rapid eye movement sleep (REM) during at least 2 naps? (After completing, go to Section 4)	Y	N
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Section 2: Obstructive Sleep Apnea-Hypopnea Syndrome

2. Does the patient have an Epworth Sleepiness score greater than or equal to 10, despite treatment with continuous positive airway pressure (CPAP)?	Y	N
3. Does the patient experience excessive sleepiness or insomnia?	Y	N
4. Does the patient experience frequent episodes of impaired breathing during sleep?	Y	N
5. Does the patient have one of the following conditions? (If yes, please circle)	Y	N
A. Associated features of OSA (ie. loud snoring, morning headaches, dry mouth upon awakening)		
B. Polysomnography demonstrating more than 5 obstructive apneas, each greater than 10 seconds in duration, per hour of sleep with frequent arousals from sleep, bradycardia, or arterial		



oxygen desaturation (After completing, go to Section 4)		
Section 3: Shift Work Sleep Disorder (SWSD)		
2. Does the patient have excessive sleepiness or insomnia associated with a work period that occurs during the usual sleep phase?	Y	N
3. Have the excessive sleepiness or insomnia symptoms occurred over at least one month?	Y	N
4. Does the patient have any other medical or mental disorders or other sleep disorders (ie. jetlag) that account for the symptoms? (After completing, go to Section 4)	Y	N
Section 4		
2. Has the patient tried and had an inadequate response to treatment with Nuvigil?	Y	N
3. If Yes to Question 2, please skip: Has the patient had an adverse drug event with a trial of Nuvigil?	Y	N

Comments: _____
Information given on this form is accurate as of this date.

Prescriber or Authorized Signature

Date

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 866-235-3062.

I understand that Catamaran’s use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).