Armodafinil/Modafinil

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Coordinated Care of Washington. Inc. Preferred Drug list: https://pharmacy.envolvehealth.com/content/dam/centene/envolve-pharmacy-solutions/pdfs/PDL/FORMULARY-CoordinatedCare_Washington.pdf

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, does patient have documentation of positive clinical response? ☐ Yes ☐ No

2. Please indicate patient's diagnosis:
   ☐ Narcolepsy with excessive somnolence, confirmed with a sleep study and multiple sleep latency test (MSLT).
   ☐ Obstructive Sleep Apnea with residual excessive somnolence, confirmed with a sleep study.
   ☐ Shift work sleep disorder
   ☐ Other. Specify: _____

3. For armodafinil, has patient tried and failed modafinil for a minimum of 60 days? ☐ Yes ☐ No

4. For patients 17 years of age or younger: Has an agency-designated mental health specialist from the Second Opinion Network (SON) performed a required second opinion review? ☐ Yes ☐ No

For diagnosis of obstructive sleep apnea, please answer the following:

5. Has patient achieved normalized breathing and oxygenation with any of the following therapies (check all that apply)?
   ☐ Continuous positive airway pressure (CPAP)
   ☐ Bilevel positive airway pressure (BIPAP)
   ☐ Other. Specify: _____

6. Does patient have documentation within the past 6 months, demonstrating adherence to any of the following (check all that apply)?
   ☐ CPAP or BIPAP therapy (CPAP or BIPAP is used for 70% of nights for a minimum of 4 hours per night)
   ☐ Mandibular advancement device
   ☐ Other. Specify: _____

7. Does the patient have documentation within the last 6 months demonstrating they are adherent to mandibular advancement device? ☐ Yes ☐ No

For diagnosis of shift work sleep disorder or sleep deprivation, please answer the following:

8. Does patient have clinical documentation that demonstrates concomitant use of nonpharmacologic interventions (i.e. counseling, sleep hygiene)? ☐ Yes ☐ No

For continuation of therapy, documentation of positive clinical response and chart notes are required.

For diagnosis of narcolepsy, provide the following:

- sleep study and multiple sleep latency test (MSLT)
- chart notes

For diagnosis of obstructive sleep apnea, provide the following:

- sleep study
- documentation of CPAP compliance (compliance report of usage) in the last 6 months
- chart notes

For diagnosis of shift work sleep disorder or sleep deprivation, provide the following:

- chart notes

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)