Nuvigil® (armodanifil) Prior Authorization Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For additional information call 800-647-2240.

Patient Name: ____ Today's Date: _____/_______/_______

Patient Pharmacy ID: __________________________________ Date of Birth: _____/_______/________
(located on bottom right of insurance card)

Requesting Physician: _________________________________ Specialty: _________________________
(Please print)

Office Contact Person: ________________________________ Phone #: (_____)_____-______ext____

Office Address: ____

Medication/dose Requested: _______________________________ Fax #: __(______)______-___________

Expected Duration of Therapy: ___________________________ ICD-9 ____________________________

1. Is the patient 16 years of age or older? Yes No
2. Does the patient have a diagnosis of:
   a. Narcolepsy or Idiopathic Hypersomnia?
      Has the diagnosis been confirmed by sleep studies? (if so, please attach) Yes No
      Has the patient been evaluated for other causes of excessive daytime sleepiness, Such as insufficient sleep syndrome, upper airway resistance syndrome, or Depression? Yes No
   b. Obstructive Sleep Apnea/Hypopnea Syndrome? Yes No
      Has the patient been on continuous positive airway pressure (CPAP) treatment for 4 or more hours per night for at least 12 weeks?
      Has the patient undergone uvulopalatopharyngoplasty surgery?
   c. Shift Work Sleep Disorder?
      Is there documentation from the patient's employee indicating patient is working variable, alternating hours, or 3rd shift? (If so, please attach) Yes No
3. Is the patient currently receiving other drugs (e.g. hypnotics) or have any medical conditions known to cause or contribute to sleepiness. ____
4. Is there another reason you are prescribing this medication? If so, please explain:
   ____

Physician's Signature: ___________________________________ Date: _____/_______/_____

For Mercy Health Plans use only: ☐ Approved Length of Approval ___________________________

☐ Denied Reason for Denial ____

Reviewer's Signature: ____________________________________ Date Reviewed: _____/______/_____

Override Entered in ☐ Caremark ☐ CCMS for _________-__________by____________________

Office Notified on ____________; at __________am/pm; by ______________ spoke to _____________________