

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**NUVIGIL** (armodafinil)

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_

Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

Requested Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL  
NECESSITY TO 855-828-4992 note the new fax number**

**CRITERIA:**

- Minimum age requirement: 17 years old.
- Covered for diagnosis:
  - Narcolepsy- Amphetamines or Methylphenidate must be tried first. Dose limited to 250mg qd.
  - Daytime somnolence due to Obstructive sleep apnea, **must be on C-pap**. Dose limited to 150mg qd.
  - Shift Work Sleep Disorder, **must be working night shifts**. Provide documentation of a treatment plan that demonstrates excessive sleepiness at work, insomnia when the patient should be sleeping. Patient must have a three month trial of sleep aids. Dose limited to 150mg/day.

**NOTES:**

Provigil and Nuvigil are mutually exclusive. Patients may only have a prior authorization for one of these medications at a time.

**AUTHORIZATON:**

1 year

**RE-AUTHORIZATION:**

Updated letter of medical necessity

9/15/10

<http://health.utah.gov/medicaid/pharmacy>