NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Antinarcolepsy: Provigil, Nuvigil, Armodafinil, and Modafanil

Beneficiary Information

1. Beneficiary Last Name: ________________________ 2. First Name: ____________________________________
3. Beneficiary ID #: ________________ 4. Beneficiary Date of Birth: ________________ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: ____
7. Requester Contact Information
Name: ____ Phone #: _______________ Ext. _____

Drug Information

8. Drug Name: __________________________ 9. Strength: _______________ 10. Quantity Per 30 Days: ________
11. Length of Therapy (in days): ☐up to 30 Days ☐60 Days ☐90 Days ☐120 Days ☐180 Days ☐365 Days ☐ Other: _________________

Clinical Information

1. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
   ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of Narcolepsy? ☐ **Yes** ☐ **No**
3. Does the beneficiary have a diagnosis of excessive sleepiness associated with shift work sleep disorder?
   ☐ **Yes** ☐ **No**
4. Does the beneficiary have excessive fatigue associated with Multiple Sclerosis or Myotonic Dystonia? ☐**Yes** ☐ **No**
5. Does the beneficiary have a diagnosis of obstructive sleep apnea/hypopnea syndrome? ☐**Yes** ☐ **No**
6. Does the beneficiary use a CPAP? ☐**Yes** ☐ **No**
7. If beneficiary is being prescribed a non-preferred medication, has the beneficiary tried and failed Provigil and Nuvigil? ☐**Yes** ☐ **No**
   7b. If no, Is there a clinical reason why the beneficiary cannot use the preferred medications? ☐**Yes** ☐ **No**
   Please explain: ____

For Continuation therapy, please answer questions 1-8

8. Has the beneficiary experienced a reduction in excessive daytime sleepiness from pre-treatment baseline as measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska SleepinessScale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)? ☐**Yes** ☐ **No**

Signature of Prescriber: ____ Date: _________________________
(Prescriber Signature Mandatory)
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189**
Pharmacy PA Call Center: **1-866-799-5318**

©WellCare 2022