Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] armodafinil 150 mg tablet [ ] armodafinil 200 mg tablet [ ] armodafinil 250 mg tablet [ ] armodafinil 50 mg tablet
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Narcolepsy

[ ] Shift-work disorder

[ ] Obstructive sleep apnea

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q4: Is the member responding positively to the armodafinil therapy? (Check only one that apply)

[ ] Yes (please provide documentation of positive clinical response to therapy)
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: Is the member responding positively to the armodafinil therapy? (Check only one that apply)

[ ] Yes (please provide documentation of positive clinical response to therapy)
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q6: What is the member's diagnosis? (Check only one that apply)

[ ] Narcolepsy

[ ] Obstructive sleep apnea

[ ] Shift-work disorder

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q7: Does the member have the diagnosis of narcolepsy confirmed by a sleep study? (Check only one that apply)

[ ] Yes (please provide the results and the date of study) _____
(*Required)

[ ] No

Q8: Is there prescriber justification confirming why a sleep study is not feasible? (Check only one that apply)

[ ] Yes (please provide the documentation supporting prescriber justification)
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q9: Is the member experiencing 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study? (Check only one that apply)

[ ] Yes (please provide the results and the date of study) _____
(*Required)

[ ] No

Q10: Is there prescriber justification confirming why a sleep study is not feasible? (Check only one that apply)

[ ] Yes (please provide the documentation supporting prescriber justification)
_____(*Required)

[ ] No

Q11: Is the member experiencing 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study? (Check only one that apply)

[ ] Yes (please provide the results and the date of study) _____ (*Required)

[ ] No

Q12: Is there prescriber justification confirming why a sleep study is not feasible? (Check only one that apply)

[ ] Yes (please provide the documentation supporting prescriber justification)
_____(*Required)

[ ] No

Q13: Is the member experiencing one of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep? (Check only one that apply)

[ ] Yes (please specify the symptom(s) and date of onset) _____ (*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q14: Has the member experienced symptoms of excessive sleepiness or insomnia associated with a work period (usually night work) that occurs during the normal sleep period for at least 3 months? (Check only one that apply)

[ ] Yes (please specify the symptom(s) and date of onset) _____ (*Required)

[ ] No _____(*Required)

Q15: Has the member done a sleep study and demonstrates loss of a normal sleep-wake pattern (i.e, disturbed chronobiologic rhythmicity)? (Check only one that apply)

[ ] Yes (please provide the results and the date of study) _____ (*Required)

[ ] No (please specify the clinical rationale for the request) _____ (*Required)

Q16: Has it been confirmed that there are no other medical conditions or medications that are causing the symptoms of excessive sleepiness or insomnia? (Check only one that apply)

[ ] Yes

[ ] No (please specify the medical condition(s) and/or medication(s))
_____(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:

Prior Authorization Form

Print Authorized Representative Name: