Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ____

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Modafinil (Provigil) and Armodafinil (Nuvigil) – Medical Necessity Request

General Information:

1. **For armodafinil requests only**: Can the prescription be changed to modafinil?
   □ Yes: Please notify the pharmacy of the change and proceed to next section.
   □ No: Please provide the clinical reason why modafinil cannot be tried, then proceed to next section.
   ____

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Narcolepsy
- a. Does the member have excessive sleepiness? **Yes or No**

□ Obstructive sleep apnea/hypopnea syndrome (OSAHS)
- a. Does the member have excessive sleepiness? **Yes or No**
- b. Has the diagnosis been confirmed by polysomnography or home sleep apnea testing? **Yes or No**
- c. Has the member been treated for the underlying obstruction with CPAP, BiPAP, oral appliances and/or surgery? **Yes or No**
  - If yes, please specify what the member has been treated with: ___________________________________
- d. Will the member continue to be treated with CPAP, BiPAP and/or oral appliances together with the requested medication (modafinil or armodafinil)? **Yes or No**
- e. Have other causes of excessive sleepiness been ruled out (e.g., non-compliance with CPAP, ill-fitting CPAP masks, insufficient sleep, poor sleep hygiene, etc.)? **Yes or No**

□ Shift work sleep disorder (SWSD)
- a. Does the member have excessive sleepiness? **Yes or No**
- b. Has the member been symptomatic for at least 3 months? **Yes or No**
- c. Does the member work at least 5 night shifts per month? **Yes or No**

□ Fatigue
- a. What is the fatigue associated with?
  - □ Multiple Sclerosis
  - □ Depression (Please answer the questions listed under the diagnosis of Depression, p. 2.)
  - □ Other: ____

□ Multiple Sclerosis
- a. Does the member have associated fatigue? **Yes or No**

Continued on p. 2

Physician office's signature*__________________________________ Print Name________________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: ___________________

□ Attention deficit hyperactivity disorder (ADHD)/ Attention deficit disorder (ADD)

a. Can the member try a formulary ADHD medication? **Yes or No** *NOTE: Formulary medications include: methylphenidate immediate-/extended-release preparation, immediate-release dexmethylphenidate, mixed-salts amphetamine immediate-/extended-release preparation, dextroamphetamine immediate-/sustained-release, atomoxetine, immediate-/extended release guanfacine.*

- If yes, please call the formulary ADHD medication prescription into the member's pharmacy.
- If no, please provide the clinical reason why a formulary medication cannot be tried?

____

b. What medication(s) has the member tried for ADHD/ADD?

____

□ Depression

a. Does the member have Major Depressive Disorder? **Yes or No**
b. Does the member have associated fatigue? **Yes or No**
c. Has the member tried and failed at least two antidepressant therapies (i.e. Fluoxetine, Paroxetine, Venlafaxine Duloxetine, Bupropion)? **Yes or No**
   - If No, can the member try an antidepressant therapy? **Yes or No**
     - If yes, please call the prescription into the member's pharmacy
     - If no, please provide the clinical reason why

____

d. Which medication(s) has the member tried?

____

e. Will the member be receiving modafinil in combination with SSRI? **Yes or No**

f. Does the member continue to have residual symptoms (i.e. fatigue, hypersomnolence)? **Yes or No**

□ Other: ____

Physician office's signature*__________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Modafinil (Provigil) and Armodafinil (Nuvigil) – Medical Necessity Request

Complete this page for Subsequent Requests

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Narcolepsy

□ Obstructive sleep apnea/hypopnea syndrome (OSAHS)

a. Will the member continue to be treated for the underlying obstruction with CPAP, BiPAP and/or oral appliances together with the requested medication (modafinil or armodafinil)? **Yes or No**

□ Shift work sleep disorder (SWSD)

a. Does the member work at least 5 night shifts per month? **Yes or No**

□ Fatigue

a. Is the fatigue associated with Multiple Sclerosis or Depression? **Yes or No**
(For Depression, please answer the questions under depression)

□ Multiple Sclerosis

a. Does the member have associated fatigue? **Yes or No**

□ Depression

a. Does the member have Major Depressive Disorder? **Yes or No**
b. Does the member have associated fatigue? **Yes or No**
c. Will the member be receiving modafinil in combination with SSRI? **Yes or No**

□ Attention deficit hyperactivity disorder (ADHD)/ Attention deficit disorder (ADD)

□ Other: ____

Physician office's signature*_________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**