CAREFIRST
Nuvigil

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Nuvigil.

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (specify drug)

_____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Does the patient have a diagnosis of narcolepsy?	**Y** ☐	**N** ☐
2.	Has the diagnosis been confirmed by sleep lab evaluation?	**Y** ☐	**N** ☐
3.	Does the patient have a diagnosis of Shift Work Disorder (SWD)?	**Y** ☐	**N** ☐
4.	Does the patient have a diagnosis of obstructive sleep apnea (OSA)?	**Y** ☐	**N** ☐
5.	Has the diagnosis been confirmed by polysomnography?	**Y** ☐	**N** ☐
6.	Has the patient been receiving treatment for the underlying airway obstruction (e.g., continuous positive airway pressure [CPAP]) for at least one month?	**Y** ☐	**N** ☐
7.	Does the patient require MORE than the plan allowance of 60 tablets per month of armofadinil (Nuvigil) 50 mg OR MORE than the plan allowance of 30 tablets per month of armodafinil (Nuvigil) 150 mg, 200 mg, 250 mg?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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