



If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

**MEMBER INFORMATION**

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

				-					-				
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Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

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Fax Number:

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**DRUG INFORMATION**

**Non-preferred Medications:**

- Armodafinil tablet (generic for Nuvigil™) 50 mg, 150 mg, 200 mg, 250 mg (QD)
- Modafinil (generic for Provigil®) 100 mg, 200 mg (QD or BID)
- Nuvigil™ 50 mg, 150 mg, 200 mg, 250 mg (QD)
- Provigil® 100 mg, 200 mg (QD or BID)
- Sunosi™ (solriamfetol) 75 mg, 150 mg
- Wakix® (pitolisant) 4.45 mg, 17.8 mg

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

<https://medproviders.anthem.com/va>

Member's Last Name:

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Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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Please select diagnosis from the following:

- Narcolepsy (*sleep study must be attached*)
- Excessive daytime sleepiness (EDS) in adult patients with narcolepsy
- Obstructive Sleep Apnea (*sleep study must be attached*)
- Shift Work Sleep Disorder:
  - Current shift schedule: \_\_\_\_\_
  - Does not occur during the course of another sleep disorder or mental disorder
  - Is not due to the direct physiological effects of a medication or a general medical condition
  - Other: \_\_\_\_\_

List pharmaceutical agents attempted and outcome: \_\_\_\_\_

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**Medical Necessity** (Provide clinical evidence that the preferred agent(s) will not provide adequate benefit and/or provide clinical rationale for quantity exception requests):

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**Prescriber Signature (Required)**

**Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the PA process.**

Submission of documentation does NOT guarantee coverage.

The completed form may be **FAXED TO 1-844-512-7020**.