

# Armodafinil (Nuvigil) Prior Authorization Request Form



5599

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> <li>The provider may <b>call: 1-866-684-4488</b> or the completed form may be <b>faxed to:</b> <b>1-866-684-4477</b></li> <li>The patient may attach the completed form to the prescription and <b>mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954</b> or <b>email</b> the form only to: <a href="mailto:TpharmPA@express-scripts.com">TpharmPA@express-scripts.com</a></li> </ul>
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Prior authorization criteria and a copy of this form are available at: <https://rxnet.army.mil/pec/formscriteria.php>

**Drug for which Prior Authorization is requested: Armodafinil (Nuvigil)**

**Step 1 Please complete patient and physician information** (Please Print)

Patient Name: \_\_\_\_\_ Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Sponsor ID# \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Secure Fax #: \_\_\_\_\_

**Step 2 Please complete the clinical assessment**

1. Does the patient have a diagnosis of narcolepsy associated with persistent and excessive daytime sleepiness as diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing?	<input type="checkbox"/> Yes Please sign and date.	<input type="checkbox"/> No Please proceed to Question 2
2. Does the patient meet BOTH of the following criteria? • A diagnosis of obstructive sleep apnea associated with persistent and excessive daytime sleepiness • Continuous positive airway pressure (CPAP) treatment has been adequately titrated and the patient is compliant with treatment	<input type="checkbox"/> Yes Please sign and date.	<input type="checkbox"/> No Please proceed to Question 3
3. Is the patient a nightshift worker with a diagnosis of shift-worker sleep disorder (SWSD) associated with excessive sleepiness?	<input type="checkbox"/> Yes Please sign and date.	<input type="checkbox"/> No Coverage not approved

**Step 3 I certify that the above is correct to the best of my knowledge** (Please sign and date):

\_\_\_\_\_

Prescriber Signature

Date