MAGELLAN COMPLETE CARE

Prior Authorization

Provigil® (modafinil)

Maximum Length of Approval = 12 Months

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID # __________ **Date of Birth (MM/DD/YYYY)** __ / __ / ____

Recipient's Full Name ______________________________

Prescriber's Full Name ______________________________

Prescriber License # (ME, OS, ARNP, PA) __________

Prescriber Phone Number ___ ___ - ____ **Prescriber Fax Number** ___ ___ - ____

INDICATION: (All Testing Should Have Been Approved in the Past 90 Days.)

☐ **Narcolepsy**

Approval is based upon the clinical interpretation of either of these tests, Multiple Sleep Latency, or Maintenance of Wakefulness. Please submit the physician's clinical interpretation of either test.

☐ **Obstructive Sleep Apnea/Hypopnea Syndrome**

Approval is based upon the clinical interpretation of either Multiple Sleep Latency/Maintenance of Wakefulness Test, or Psychomotor Vigilance Task, or Steer Clear Performance AND concurrent use of Continuous Positive Airway Pressure, CPAP with significant compliance. Please submit the physician's clinical interpretation of either battery of tests. In addition, please submit documentation of usage of CPAP.

☐ **Shift Work Sleep Disorder**

Approval is based upon the clinical interpretation of either Multiple Sleep Latency/Maintenance of Wakefulness Test, and the patient's night shift work schedule (provided by the patient's supervisor).

DOSAGE:

Provigil _______________________ mg Q ________________________ Hrs for ________________________ Months

PRESCRIBER'S SIGNATURE: ____ **DATE**: ___________________________

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Magellan Complete Care

MCC Physician Review: I do not recommend Approval. I recommend Approval for _________ months.

MCC Physician Signature: _________________________________ **Date:** ____________________________

Fax or mail completed forms to:

Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

Approved Indications:

- Narcolepsy
  - ❒ Diagnosis supported by clinical testing and a physician's interpretation of these tests confirming the diagnosis.
- Obstructive Sleep Apnea/Hypopnea Syndrome
  - ❒ This syndrome being confirmed by clinical testing, a physician's interpretation of the tests supporting the diagnosis, and the confirmation of the patient's concurrent use of CPAP.
- Shift Work Sleep Disorder
  - ❒ This disorder being confirmed by a physician's interpretation of clinical testing and documentation by the patient's supervisor of at least 10 night shifts worked out of the past 30 days.

Approval Period:

Maximum of 12 months