Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Antinarcolepsy: Provigil, Nuvigil, Armodafinil, and Modafanil

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
2. Requestor Name (Nurse/Office Staff): _____
3. Mailing Address: _____ City: _____ State: ____ Zip: _____
4. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

For Initial Authorization, please answer questions 1-7

1. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
   ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of Narcolepsy? ☐ **Yes** ☐ **No**
3. Does the member have a diagnosis of excessive sleepiness associated with Shift Work Sleep Disorder?
   ☐ **Yes** ☐ **No**
4. Does the member have excessive fatigue associated with Multiple Sclerosis or Myotonic Dystonia? ☐ **Yes** ☐ **No**
5. Does the member have a diagnosis of Obstructive Sleep Apnea-/ Hypopnea Syndrome? ☐ **Yes** ☐ **No**
6. Does the member use a CPAP? ☐ **Yes** ☐ **No**
7. If the member is being prescribed non-preferred modafanil, has the member tried and failed Provigil and Nuvigil? ☐ **Yes** ☐ **No**
   a. If 'NO', state a clinical reason why the member cannot use the preferred Brand medications:
      _____

For Continuation therapy, please answer questions 1-8

8. Has the member experienced a reduction in excessive daytime sleepiness from pre-treatment baseline as measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.