Catamaran Prior Authorization Department
Phone: 866-235-3062
Fax: 866-391-7222

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone ___-___-____	**Fax** ___-___-____

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:** __-__-____

Medication Information:

Drug Name and Strength: _____	Quantity and Dosing: _____
Diagnosis: _____	Duration: _____

Modafinil
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. What is the patient's diagnosis? **(Please circle)** A. Narcolepsy B. Obstructive Sleep Apnea-Hypopnea Syndrome C. Shift-work Sleep Disorder (SWSD) D. Other: _____		
Narcolepsy		
2. Has the patient received a Multiple Sleep Latency Test (MSLT) and the patient has a mean sleep latency of less than 10 minutes with documented rapid eye movement sleep (REM) during at least 2 naps?	Y	N
3. Has the patient tried and had an inadequate response to treatment with Nuvigil?	Y	N
4. Has the patient had an adverse drug event with a trial of Nuvigil?	Y	N
Obstructive Sleep Apnea-Hypopnea Syndrome		
2. Does the patient have an Epworth Sleepiness score greater than or equal to 10, despite treatment with continuous positive airway pressure (CPAP)?	Y	N
3. Does the patient experience excessive sleepiness or insomnia?	Y	N
4. Does the patient experience frequent episodes of impaired breathing during sleep?	Y	N
5. Does the patient have one of the following conditions? **(If yes, please circle)** A. Associated features of OSA (ie. loud snoring, morning headaches, dry mouth upon awakening)	Y	N

B. Polysomnography demonstrating more than 5 obstructive apneas, each greater than 10 seconds in duration, per hour of sleep with frequent arousals from sleep, bradytachycardia, or arterial oxygen desaturation		
6. Has the patient tried and had an inadequate response to treatment with Nuvigil?	Y	N
7. Has the patient had an adverse drug event with a trial of Nuvigil?	Y	N
Shift Work Sleep Disorder		
2. Does the patient have excessive sleepiness or insomnia associated with a work period that occurs during the usual sleep phase?	Y	N
3. Have the excessive sleepiness or insomnia symptoms occurred over at least one month?	Y	N
4. Does the patient have any other medical or mental disorders or other sleep disorders (ie. jetlag) that account for the symptoms?	Y	N
5. Has the patient tried and had an inadequate response to treatment with Nuvigil?	Y	N
6. Has the patient had an adverse drug event with a trial of Nuvigil?	Y	N

Comments: _____

Information given on this form is accurate as of this date.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 866-235-3062.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).