



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

Prescriber Information

Last Name: <input type="text"/> DEA/NPI: <input type="text"/> Phone <input type="text"/>	First Name <input type="text"/> Specialty: <input type="text"/> Fax <input type="text"/>
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Member Information

Last Name: <input type="text"/> Member ID Number <input type="text"/>	First Name <input type="text"/> DOB: <input type="text"/>
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Medication Information:

Drug Name and Strength: <input type="text"/> Diagnosis: <input type="text"/>	Quantity and Dosing: <input type="text"/> Duration: <input type="text"/>
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Nuvigil Prior Authorization Criteria

You must answer ALL of the following questions

1. What is the patient's diagnosis? (Please circle) <ul style="list-style-type: none"> Narcolepsy Obstructive Sleep Apnea-Hypopnea Syndrome Shift-work Sleep Disorder (SWSD) Other: _____ 		
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. Does the patient have an Epworth Sleepiness score greater than or equal to 10, despite treatment with continuous positive airway pressure (CPAP)?	Y	N
4. Does the patient experience excessive sleepiness or insomnia?	Y	N
5. Does the patient experience frequent episodes of impaired breathing during sleep?	Y	N
6. Does the patient have one of the following conditions? <ul style="list-style-type: none"> Associated features of OSA (ie. loud snoring, morning headaches, dry mouth upon awakening) Polysomnography demonstrating more than 5 obstructive apneas, each greater than 10 seconds in duration, per hour of sleep with frequent arousals from sleep, bradycardia, or arterial oxygen desaturation 	Y	N
7. Does the patient have excessive sleepiness or insomnia associated with a work period that occurs during the usual sleep phase?	Y	N
8. Have the excessive sleepiness or insomnia symptoms occurred over at least one month?	Y	N
9. Does the patient have any other medical or mental disorders or other sleep disorders (ie. jetlag) that	Y	N



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account for the symptoms?

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).