TEXAS MEDICAID
Clinical Edit Prior Authorization
modafinil (PROVIGIL)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

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STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 16 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of narcolepsy or shift work disorder in the last 730 days?

   ☐ Yes (Go to #5) ☐ No (Go to #3)

3. Does the client have a diagnosis of obstructive sleep apnea in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have a procedure code for continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP) in the last 730 days?

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have a diagnosis of severe hepatic impairment in the past 365 days?

   ☐ Yes (Go to #6) ☐ No (Go to #7)

6. Is the dose less than or equal to (≤) 100 mg per day?

   ☐ Yes (Approve – 365 days) ☐ No (Deny)

7. Is the dose less than or equal to (≤) 200 mg per day?

   ☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.