



TEXAS MEDICAID Clinical Edit Prior Authorization armodafinil (NUVIGIL)

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)



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

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

Yes (Go to #2)

No (Deny)

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

Yes (Go to #3)

No (Go to #4)

3. Is the dose less than or equal to (\leq) 150 mg per day?

Yes (Approve – 365 days)

No (Deny)

4. Does the client have a diagnosis of narcolepsy in the last 730 days?

Yes (Go to #7)

No (Go to #5)

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

Yes (Go to #6)

No (Deny)

6. 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 #7)

No (Deny)

7. Is the dose less than or equal to (\leq) 250 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.