Prescriber Criteria Form

Nuvigil 2025 PA Fax 1442-A v2 010125.docx
Nuvigil (armodafinil)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Nuvigil (armodafinil).

Drug Name:
Nuvigil (armodafinil)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of excessive sleepiness associated with narcolepsy? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Has the diagnosis been confirmed by sleep lab evaluation? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of excessive sleepiness associated with Shift Work Disorder (SWD)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)? [If no, then no further questions.]	Yes ◯	No ◯
5	Has the diagnosis been confirmed by polysomnography?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____