

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**MEMBER INFORMATION**

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name:

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First Name:

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NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

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**DRUG INFORMATION****Non-preferred Medications:**

- Armodafinil tablet (generic for Nuvigil®) 50 mg, 150 mg, 200 mg, 250 mg (QD)
- Modafinil (generic for Provigil®) 100 mg, 200 mg (QD or BID)
- Nuvigil® 50 mg, 150 mg, 200 mg, 250 mg (QD)
- Provigil® 100 mg, 200 mg (QD or BID)
- Sunosi™ (solriamfetol) 75 mg, 150 mg
- Wakix® (pitolisant) 4.45 mg, 17.8 mg

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

Member's Last Name:

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Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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Please select diagnosis from the following:

- Narcolepsy (sleep study must be attached)
- Excessive daytime sleepiness (EDS) in adult patients with narcolepsy
- Obstructive Sleep Apnea (sleep study must be attached)
- Sudden onset of weak or paralyzed muscles (cataplexy)
- Shift Work Sleep Disorder
  - Current shift schedule: \_\_\_\_\_
  - Does not occur during the course of another sleep disorder or mental disorder
  - Is not due to the direct physiological effects of a medication or a general medical condition
  - Other: \_\_\_\_\_

List pharmaceutical agents attempted and outcome:

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**Medical Necessity:** Provide clinical evidence that the preferred agent(s) will not provide adequate benefit and/or provide clinical rationale for quantity exception requests:

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**Prescriber Signature (Required)**

**Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the SA process.**

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services. The completed form may be faxed to **1-800-424-7581**, phoned to **1-800-424-4518 (TTY 711)** or mailed to:

**Magellan Rx Management Prior Authorization Program**  
**c/o Molina Complete Care**  
**11013 West Broad Street**  
**Glen Allen, VA 23060**

[www.MCCofVA.com](http://www.MCCofVA.com)