PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **NARCOLEPSY AGENTS**

BRAND NAME **NUVIGIL**
(generic) **(armodafinil)**

Status: Client Requested Criteria
Type: Initial Prior Authorization ***Ref # C10439-A***

CRITERIA FOR APPROVAL

1	Does the patient have a diagnosis of narcolepsy confirmed by sleep lab evaluation? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of Shift Work Disorder (SWD)? [If yes, then no further questions.]	Yes	No
3	Does the patient have a diagnosis of obstructive sleep apnea (OSA) confirmed by polysomnography? [If yes, then no further questions.]	Yes	No
4	Does the patient have a diagnosis of idiopathic hypersomnia confirmed by polysomnography? [If yes, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of fatigue associated with multiple sclerosis (MS	Yes	No

Mapping Instructions		
	Yes	**No**
1.	Approve, 12 months	Go to 2
2.	Approve, 12 months	Go to 3
3.	Approve, 12 months	Go to 4
4.	Approve, 12 months	Go to 5
5.	Approve, 12 months	Deny

REFERENCES

1. NCSHP Prior Authorization Approval Policy.

Written by: UM Development (JG)
Date Written: 04/2017
Revised:
Reviewed: Medical Affairs (ME) 05/2017

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

Signature

Date

Client Name