

# PRIOR AUTHORIZATION CRITERIA

**DRUG CLASS**                      **NARCOLEPSY AGENTS**

**BRAND NAME**                      **PROVIGIL**  
**(generic)**                              **(modafinil)**

**Status: Client Requested Criteria**  
**Type: Initial Prior Authorization**

**Ref # C10438-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 Instruction

	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