

PROVIGIL (modafinil)

PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. Has the patient experienced an inadequate treatment response or intolerance to a 30 days supply of Nuvigil in the last 365 days? Y N
[If the answer to this question is no, then no further questions required.]
2. Is the patient using Provigil for fatigue related to multiple sclerosis? Y N
[If the answer to this question is yes, then no further questions required.]
3. Does the patient have a diagnosis of narcolepsy? Y N
[If the answer to this question is no, skip to question 5.]
4. Has the diagnosis of narcolepsy been confirmed by sleep lab evaluation? Y N
[No further questions required.]
5. Does the patient have a diagnosis of obstructive sleep apnea/hypopnea syndrome? Y N
[If the answer to this question is no, skip to question 12.]
6. Has the diagnosis of obstructive sleep apnea/hypopnea syndrome been confirmed by polysomnography with respiratory monitoring? Y N
[If the answer to this question is no, then skip to question 12.]

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7. Is the patient currently, within the last 60 days, utilizing continuous positive airway pressure (CPAP) therapy? Y N
[If the answer to this question is yes, then no further questions required.]
8. Is CPAP therapy contraindicated for the patient, or has CPAP therapy been tried and found to be ineffective for the patient even when the patient was compliant with the therapy? Y N
[If the answer to this question is yes, then no further questions required.]
9. Does the patient have mild obstructive sleep apnea/hypopnea syndrome? Y N
[If the answer to this question is no, skip to question 12.]
10. Is the patient using an oral appliance? Y N
[If the answer to this question is no, skip to question 12.]
11. Is the patient compliant with oral appliance use? Y N
[If the answer to this question is yes, then no further questions required.]
12. Does the patient have a diagnosis of Shift Work Sleep Disorder (SWSD)? Y N
[If the answer to this question is no, then no further questions required.]
13. Does the patient work the night shift (at least 6 hours between the hours of 10 pm and 8 am) permanently? Y N
[If the answer to this question is yes, then skip to question 15.]
14. Does the patient work the night shift (at least 6 hours between the hours of 10 pm and 8 am) frequently (5 times or more per month)? Y N
15. Does the patient experience excessive sleepiness while working? Y N

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date:
