



**Independence
Blue Cross**

Prior Authorization Form

Provigil® (modafinil)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: **Provigil®** (modafinil)

Date _____ Patient's ID#: _____ DOB: _____
 Patient's Name _____ Provider NPI: _____
 Prescribing Physician _____ Office Contact: _____
 Office Fax# _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. **PROVIDER SPECIALTY** (specify): Neurologist Sleep Specialist
 Other: _____

2. **DIAGNOSIS FOR DRUG REQUESTED:**
 Narcolepsy
 Idiopathic Hypersomnia
 Obstructive Sleep Apnea/Hypopnea Syndrome
 Shift Work Sleep Disorder
 Fatigue associated with multiple sclerosis
 Other (*specify*): _____

3. **PATIENT HISTORY:**
 Was a sleep study conducted? Yes No
 Diagnosis (*resulting from sleep study*): _____
 Clinical evaluation demonstrating presence of a shift work schedule likely to result in sleepiness?
 Yes No
 Clinical evaluation showing failure of patient counseling regarding techniques for reducing the negative effects of shift work (napping, bright light, avoidance, or request for change in shift, etc.)?
 Yes No

Please add any supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only	Coverage effective date / /
Document # _____	Processor Initials _____ Date _____
M F Rx coverage Y N	STANDARD - SELECT LOB _____
Previous Auth Y N	Approved Reviewer Initials _____ Date _____