



**Independence
Blue Cross**

Prior Authorization Form

Provigil® (modafinil)/Nuvigil® (armodafinil)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

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

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:

a. Was a sleep study conducted? Diagnosis (<i>resulting from sleep study</i>): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
b. Clinical evaluation demonstrating presence of a shift work schedule likely to result in sleepiness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
c. Clinical evaluation showing failure of patient counseling regarding techniques for reducing the negative effects of shift work (<i>napping, bright light, avoidance, or request for change in shift, etc.</i>)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
d. Does the patient have a history of medical or mental disorder that accounts for the symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
e. Does the patient have any sleep disorders that produce insomnia or excessive sleepiness (e.g. time-zone change syndrome)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
f. Does the patient have a primary complaint of insomnia or excessive sleepiness temporarily associated with work period that occurs during the habitual sleep phase or Polysomnography and the multiple sleep latency test (MSLT) that demonstrated a loss of normal sleep wake pattern?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
g. Does the patient currently use Continuous Positive Airway Pressure (CPAP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

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 _____