



AmeriHealth

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
 Obstructive Sleep Apnea/Hypopnea Syndrome
 Shift Work Sleep Disorder
 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 (napping, bright light, avoidance, or request for change in shift, etc.)?	<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