

Provigil (modafinil)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueChoice® HealthPlan

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax back to Caremark at 888-836-0730.

This fax machine is located in a HIPAA-compliant secure location.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

On behalf of BlueChoice HealthPlan, Caremark assists in the administration of this program.

Caremark is an independent company that administers prescription drug benefits.

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

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

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature: 	Date:
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