



PRIOR AUTHORIZATION FORM



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:

Table with 2 columns: Question and Yes/No/N/A options. Questions include: Was a sleep study conducted?, Clinical evaluation demonstrating presence of a shift work schedule likely to result in sleepiness?, 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.)?, Does the patient have a history of medical or mental disorder that accounts for the symptoms?, Does the patient have any sleep disorders that produce insomnia or excessive sleepiness (e.g. time-zone change syndrome)?, Did the patient have a Polysomnography and the multiple sleep latency test (MSLT) that demonstrated a loss of normal sleep wake pattern?, Does the patient currently use Continuous Positive Airway Pressure (CPAP)?

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