Prior Authorization Request Form for Provigil (modafinil)

Member Information

Patient Name _____

Cardholder ID _____

Date of Birth _____

Address _____

City, State Zip _____

Phone Number _____

Provider Information

Provider Name _____

DEA Number _____

Address _____

City, State and Zip _____

Phone Number _____

FAX Number _____

Pharmacy Information

Pharmacy Name_____Address_____Phone_____

Criteria for Approval:

1. **Provigil 100mg ☐ 200mg ☐**
2. Is the patient 18 years of age or older? Yes☐ No ☐
3. Has the patient been on Provigil therapy for the previous 6 months? Yes☐ No ☐
4. Diagnosis of Narcolepsy? Yes☐ No ☐
5. Diagnosis of obstructive sleep apnea? Yes☐ No ☐
6. Diagnosis of Shift Work Sleep Disorder (SWSD)? Yes☐ No ☐
7. Have any of the following requirements been met? *Check all that apply:* Yes☐ No☐
   - ☐ Narcolepsy has been present for the previous 6 months
   - ☐ Narcolepsy confirmed in sleep studies
   - ☐ No other extraneous causes for excessive daytime sleepliness (i.e., depression, insufficient sleep syndrome, nighttime insomnia, or upper airway resistance syndrome, medication)
   - ☐ Patient is currently undergoing continuous positive airway pressure (CPAP) therapy

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received_____

Reference Number_____

Approved / Denied (Circle One) by _____ Date_____

Date/Time Returned to Provider_____

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If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
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Tallahassee, FL 32308

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