

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 sleepiness (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 _____

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
3375-I Capital Circle NE
Tallahassee, FL 32308

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