Prior Authorization Criteria Form

CAREMARK FAX FORM

Provigil

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-888-836-0730**.
Please contact CVS|Caremark at **1-888-414-3125** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Provigil.

Drug Name (select from list of drugs shown)

Provigil (modafinil)

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each applicable question.

1.	Does the member have a diagnosis of narcolepsy?	Y N
	[If the answer to this question is no, skip to question 3.]	
2.	Has the diagnosis of narcolepsy been confirmed by sleep lab evaluation?	Y N
	[No further questions are required.]	
3.	Does the member have a diagnosis of obstructive sleep apnea/hypopnea syndrome?	Y N
	[If the answer to this question is no, skip to question 10.]	
4.	Has the diagnosis of obstructive sleep apnea/hypopnea syndrome been confirmed by polysomnography with respiratory monitoring?	Y N
	[If the answer to this question is no, skip to question 10.]	
5.	Is the member currently utilizing continuous positive airway pressure (CPAP) therapy?	Y N
	[If the answer to this question is yes, no further questions are required.]	
6.	Is CPAP therapy contraindicated for the member, or has CPAP therapy been tried and found to be ineffective for the member even when the member was compliant with the therapy?	Y N

	[If the answer to this question is yes, no further questions are required.]
7.	Does the member have mild obstructive sleep apnea/hypopnea syndrome? Y N
	[If the answer to this question is no, skip to question 10.]
8.	Is the member using an oral appliance? Y N
	[If the answer to this question is no, skip to question 10.]
9.	Is the member compliant with oral appliance use? Y N
	[If the answer to this question is yes, no further questions are required.]
10.	Does the member have a diagnosis of Shift Work Sleep Disorder (SWSD)? Y N
	[If the answer to this question is no, no further questions are required.]
11.	Does the member work the night shift (at least 6 hours between the hours of 10 pm and 8 am) permanently? Y N
	[If the answer to this question is yes, skip to question 13.]
12.	Does the member work the night shift (at least 6 hours between the hours of 10 pm and 8 am) frequently (5 times or more per month)? Y N
13.	Does the member experience excessive sleepiness while working? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date