Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

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 **1-800-294-5979** 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)

Modafinil Tablets  Provigil (modafinil)

Quantity  Frequency  Strength

Route of Administration  Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

Comments: _____

**Please circle the appropriate answer for each question.**

| | |
|---|---|
| 1. Does the patient have a diagnosis of narcolepsy confirmed by sleep lab evaluation? | Y N |
| [If yes, then no further questions.] | |
| 2. Does the patient have a diagnosis of Shift Work Disorder (SWD)? | Y N |
| [If yes, then no further questions.] | |
| 3. Does the patient have a diagnosis of obstructive sleep apnea (OSA) confirmed by polysomnography? | Y N |
| [If yes, then no further questions.] | |

| | | |
|---|---|---|
| 4. | Is the requested drug being prescribed for Multiple Sclerosis-related fatigue? | Y N |
| 5. | Has the patient experienced an inadequate treatment response, intolerance, or contraindication to amantadine? | Y N |

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

| |
|---|
| **Prescriber (Or Authorized) Signature and Date** |