

# Drug Coverage Review Request

## Modafinil (Provigil)<sup>®</sup>, Armodafinil (Nuvigil)<sup>®</sup>



### SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

#### PATIENT

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

#### PATIENT

Cardholder ID # \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

### SECTION A Please answer the following questions

- Yes  No Will this patient be receiving this drug in COMBINATION with a CNS stimulant or atomoxetine (*Strattera*)?
- If the **prescribed drug** is *Provigil*, for which indication is this drug being prescribed?
  - Idiopathic hypersomnolence → continue to **step 1**
  - Depression associated with fatigue and/or sleepiness → continue to **step 2**
  - Excessive daytime sleepiness due to obstructive sleep apnea → continue to **step 3**
  - Shift work sleep disorder (SWSD) → continue to **step 4**
  - Narcolepsy → continue to **step 5**
  - Other
- If the **prescribed drug** is *Nuvigil*, for which indication is this drug being prescribed?
  - Excessive daytime sleepiness due to obstructive sleep apnea → continue to **step 3**
  - Shift work sleep disorder (SWSD) → continue to **step 4**
  - Narcolepsy → continue to **step 5**
  - Other

### STEP 1 Please complete step 1 if diagnosis is idiopathic hypersomnolence

- Yes  No Has the diagnosis of idiopathic hypersomnolence been confirmed by sleep studies (polysomnography) to rule out disorders such as narcolepsy, obstructive sleep apnea, or posttraumatic hypersomnia?

### STEP 2 Please complete step 2 if diagnosis is depression associated with fatigue and/or sleepiness

- Yes  No Is the patient receiving antidepressant drug therapy?
- Yes  No Has the patient been receiving this drug for at least 8 weeks?
- Yes  No **If yes to the previous question**, is this drug continuing to provide clinical benefit (for example, improvement in depression associated with fatigue and/or sleepiness)?



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Form # FL91650

**STEP 3** Please complete step 3 if diagnosis is excessive daytime sleepiness due to obstructive sleep apnea

- Yes  No Will this drug be used in conjunction with continuous positive airway pressure (CPAP) therapy?
- Yes  No Is the patient a CANDIDATE for continuous positive airway pressure (CPAP) therapy?

**STEP 4** Please complete step 4 if diagnosis is shift work sleep disorder (SWSD)

- Yes  No Is the patient a night shift worker?
- Yes  No Does the patient have complaints of persistent and frequent excessive sleepiness and/or falling asleep while at work?
- Yes  No Is the patient on drugs such as hypnotics or sleeping pills or any other substances that can cause or contribute to sleepiness?
- Yes  No **If yes to the previous question**, have these drugs been DISCONTINUED by the patient?
- Yes  No Does the patient have any medical conditions known to cause or contribute to sleepiness?
- Yes  No **If yes to the previous question**, has the presence of this medical condition been considered and treated?

**Step 5** Please complete step 5 if diagnosis is narcolepsy

- Yes  No Does the patient have any OTHER conditions which may contribute to or worsen excessive daytime sleepiness?
- Yes  No **If yes to the previous question**, has the presence of any OTHER CONDITIONS known to contribute to or worsen excessive daytime sleepiness been ADDRESSED AND TREATED?

**SECTION B** Physician Signature

\_\_\_\_\_

PHYSICIAN SIGNATURE

\_\_\_\_\_

DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET



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