P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

# PREAUTHORIZATION FORM

## Provigil™ and Nuvigil™
## (modafinil and armodafinil)

**Therapeutic use:** wakefulness promoting stimulant medication

**Quantity Limit:**

- Provigil: 30 per month of the 100 mg tablets; 60 per month of the 200 mg tablets
- Nuvigil: 30 tablets per month

**Authorization Period:** 12 months

Patient's name _____

Patient's ID# ☐☐☐☐☐☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐☐☐☐☐☐☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

| Please check "Yes" or "No" and respond to the following requests: | | | |
|---|---|---|---|
| 1. | Which medication is being requested? ❑ Provigil ❑ Nuvigil Requested dose:_____ | | |
| 2. | Is the patient being treated for **obstructive sleep apnea/hypopnea syndrome (OSAHS)**? | ❑ Yes | ❑ No |
| 2a. | Has OSAHS been diagnosed by a sleep specialist?<br>If so, please list sleep specialist:_____ | ❑ Yes | ❑ No |
| 2b. | Has the patient been compliant with CPAP? | ❑ Yes | ❑ No |
| 3. | Is the patient being treated for **narcolepsy**? | ❑ Yes | ❑ No |
| 3a. | Has narcolepsy been diagnosed by a sleep specialist?<br>If so, please list sleep specialist:_____ | ❑ Yes | ❑ No |
| 4 | Has the patient been diagnosed with **Shift Work Sleep Disorder (SWSD)**? | ❑ Yes | ❑ No |
| 4a. | Has the patient had a primary complaint of insomnia or excessive sleepiness? | ❑ Yes | ❑ No |
| 4b. | Have the symptoms lasted for three (3) or more months? | ❑ Yes | ❑ No |
| 4c. | Does the patient's alternative work schedule meet the following criteria:<br>(please check all that apply)<br>❑ Six (6) or more hours of the shift between 10pm and 8am<br>❑ Twelve (12) or less hours per shift<br>❑ Five (5) or more alternative shifts per month<br>❑ Three (3) or more consecutive shifts per month) | ❑ Yes | ❑ No |

**This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.**

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