



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Provigil (Medicare Prior Authorization)**

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 (Medicare Prior Authorization).

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



Arkansas BlueCross BlueShield

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