EXPRESS SCRIPTS®

Prior Authorization Form
Nuvigil and Provigil

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Nuvigil 50mg Tablet
- ☐ Nuvigil 150mg Tablet
- ☐ Nuvigil 250mg Tablet
- ☐ Provigil 100mg Tablet
- ☐ Provigil 200mg Tablet

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:

1. What is the indication or diagnosis?
   - ☐ ADHD/ADD
   - ☐ Adjunctive/augmentation treatment of depression in adults
   - ☐ Cancer-related fatigue
   - ☐ Excessive daytime sleepiness due to myotonic dystrophy
   - ☐ Excessive daytime sleepiness in Parkinsons disease
   - ☐ Excessive sleepiness due to obstructive sleep apnea/hypopnea syndrome (OSAHS)
   - ☐ Excessive sleepiness due to shift work sleep disorder (SWSD)
   - ☐ Fatigue associated with HIV infection
   - ☐ Fatigue associated with Multiple Sclerosis (MS)
   - ☐ Fatigue or sleepiness associated with chronic use of narcotic analgesics
   - ☐ Idiopathic hypersomnia
   - ☐ Myasthenia gravis
   - ☐ Narcolepsy
   - ☐ Other: _____ _____

2. If the diagnosis is OSAHS, has the patient tried continuous positive airway pressure (CPAP)?	☐ Yes	☐ No	☐ N/A
3. If the diagnosis is SWSD, please indicate how many overnight shifts the patient works per month: _____			☐ N/A

4. If the diagnosis is fatigue or sleepiness associated with HIV infection **OR** chronic use of narcotic analgesics, has the patient tried one CNS stimulant (for example: methylphenidate [Ritalin], dextroamphetamine [Dexedrine, Dextrostat])? If yes, please document CNS stimulant tried: _____ _____	☐ Yes	☐ No	☐ N/A
5. If the diagnosis is ADHD/ADD, has the patient tried two alternative medications for ADHD/ADD? Alternatives must be from two different classes as follows: 1. Methylphenidate products 2. Amphetamines 3. Strattera (atomoxetine) 4. Wellbutrin (bupropion) 5. TCAs (tricyclic antidepressants) 6. Alpha-agonists (e.g., Kapvay, Intuniv) Please document alternative medications tried: _____ _____	☐ Yes	☐ No	☐ N/A
6. If the diagnosis is adjunctive/augmentation treatment of depression in adults, is the patient concurrently receiving other medication therapy for depression? If yes, please document other drug therapy: _____ _____	☐ Yes	☐ No	☐ N/A
7. If the diagnosis is idiopathic hypersomnia, has the diagnosis been confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (e.g., sleep center)?	☐ Yes	☐ No	☐ N/A

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.