ProCare Rx

Provigil® modafinial

Ticket #: ______________ Request Date: ______________ Request Time: ______________

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Provigil®** modafinial. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information)

INDICATION: All testing should have been approved in the past 90 days.

☐ Narcalepsy

Approval is based upon the clinical interpretation of either of these tests, Multiple Sleep Latency or Maintenance of Wakefulness. Please submit the physician's clinical interpretation with the test.

☐ Obstructive Sleep Apnea/Hypopnea Syndrome

Approval is based upon the clinical interpretation of either Multiple Sleep Latency/Maintenance of Wakefulness Test, or Psychomotor Vigilance Task, or Steer Clear Performance AND concurrent use of Continuous Positive Airway Pressure, CPAP with significant compliance. Please submit the physician's clinical interpretation of either battery of tests. In addition, please submit documentation of usage of CPAP.

☐ Shift Work Disorder

Approval is based upon the clinical interpretation of the Multiple Sleep Latency/Maintenance of Wakefulness Test, and the patient's night shift work schedule. (provided by the patient's supervisor)

DOSAGE: Provigil ______________mg Q ______________Hrs for ______________Months

Authorized Medical Signature:	
Telephone:	Date:

<u>When Completed Return To</u>:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.