

**Physician's Prior Authorization Questionnaire
Provigil®**

Patient: _____ **ID#:** _____ **DOB:** _____

Patient Address: _____

Provigil® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? _____

For **Narcolepsy** diagnosis: Submit the multiple sleep latency testing and/or polysomnography test results.

For **Obstructive Sleep Apnea** diagnosis: Submit the patient log from a nasal CPAP machine for the last 60 days showing the average usage time and the interval over which it is reported.

For **Shift-Work Disorder** diagnosis: Submit medical records, work schedule, and type of work.

2. Describe the patient's somnolence, with particular attention to any risk or social compromise it poses.

3. Does the patient take any CNS depressants such as tranquilizers, sedatives, or sleep medication?

Yes No

If Yes, please list: _____

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx