Provigil
(modafinil)

Express Scripts
Prior Authorization
Phone (800) 417- 8164
Fax 877-837-5922

Please have the information below ready when calling in the authorization.

Member's Last Name	Member's First Name
SCAN ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:

1. Is the diagnosis or indication for the treatment of excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS)? If No, continue to #3.
2. Has the patient tried and failed continuous positive airway pressure (CPAP)?
3. Is the diagnosis or indication for the treatment of shift work sleep disorder (SWSD)?
4. Is the diagnosis or indication for the treatment of narcolepsy? If yes, continue to #5.
5. Has the patient tried and failed both methylphenidate and dextroamphetamine?
6. Are there any other comments, diagnoses, symptoms, and/or any other information you feel is important to this review?

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.