



**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:
-------------	------------

<b>1. Is the diagnosis or indication for the treatment of excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS)? If no continue to #4</b>
<b>2. Is continuous positive airway pressure (CPAP) considered to be the treatment of choice for these patients? If yes, continue to #3.</b>
<b>3. Has the patient tried and failed continuous positive airway pressure (CPAP)?</b>
<b>4. Is the diagnosis or indication for the treatment of shift work sleep disorder (SWSD)? If no, continue to #5</b>
<b>5. Is the diagnosis or indication for the treatment of narcolepsy?</b>
<b>6. Has the patient tried and failed both methylphenidate and dextroamphetamine? If no, continue to #7.</b>
<b>7. Does the patient have a documented history of stimulant drug abuse/ dependence or other contraindications to methylphenidate and dextroamphetamine?</b>
<b>8. Are there any other comments, diagnoses, symptoms, and/or any other information you feel is important to this review?</b>

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>.