



**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 |
| VH ID number       | Date of Birth       |
| Prescriber's Name  | Contact Person      |
| Office phone       | Office Fax          |

|             |            |
|-------------|------------|
| Medication: | Diagnosis: |
|-------------|------------|

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| <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 #3.</b> |
| <b>2. Has the patient tried and failed continuous positive airway pressure (CPAP)?</b>   |
| <b>3. Is the diagnosis or indication for the treatment of shift work sleep disorder (SWSD)? If no, continue to #4.</b>   |
| <b>4. Is the diagnosis or indication for the treatment of narcolepsy? If yes, continue to #5.</b>  |
| <b>5. Has the patient tried and failed both methylphenidate and dextroamphetamine?</b>   |
| <b>6. 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>.