Prescriber Criteria Form

Provigil 2025 PA Fax 1450-A v2 010125.docx
Provigil (modafinil)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Provigil (modafinil).

Drug Name:
Provigil (modafinil)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of excessive sleepiness associated with narcolepsy? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Has the diagnosis been confirmed by sleep lab evaluation? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of excessive sleepiness associated with Shift Work Disorder (SWD)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)? [If no, then skip to question 6.]	Yes ◯	No ◯
5	Has the diagnosis been confirmed by polysomnography? [No further questions.]	Yes ◯	No ◯
6	Is the requested drug being prescribed for the treatment of idiopathic hypersomnia (IH)? [If no, then no further questions.]	Yes ◯	No ◯
7	Is this a request for continuation of therapy? [If no, then skip to question 9.]	Yes ◯	No ◯

8	Has the patient experienced a decrease in daytime sleepiness from baseline? [No further questions.]	Yes ◯	No ◯
9	Does the patient meet ALL of the following: A) patient has experienced lapses into sleep or an irrepressible need to sleep during daytime, on a daily basis, for at least 3 months, B) insufficient sleep syndrome is confirmed absent, C) cataplexy is absent, D) fewer than 2 sleep onset rapid eye movement periods (SOREMPs) OR no SOREMPs, if the rapid eye movement latency on an overnight sleep study was less than or equal to 15 minutes, E) average sleep latency of less than or equal to 8 minutes on Multiple Sleep Latency Test OR total 24-hour sleep time is greater than or equal to 11 hours, F) another condition (sleep disorder, medical or psychiatric disorder, or drug/medication use) does not better explain the hypersomnolence and test results?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____