OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Provigil® (modafinil) Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below and complete the corresponding questions for that diagnosis:

- ❑ Adjunctive therapy for the treatment of major depressive disorder or bipolar depression
- ❑ Fatigue due to multiple sclerosis
- ❑ Idiopathic hypersomnia
- ❑ Narcolepsy
- ❑ Obstructive sleep apnea/hypopnea syndrome (OSAHS)
- ❑ Shift work sleep disorder (SWSD)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Adjunctive therapy for the treatment of major depressive disorder or bipolar depression:

Does the patient have a history of trial and failure, contraindication, or intolerance to at least two antidepressants from different classes (e.g., SSRI, SNRI, bupropion)? ❑ **Yes** ❑ **No**

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to Provigil (modafinil) therapy? ❑ **Yes** ❑ **No**

Fatigue due to multiple sclerosis:

For brand Provigil requests, select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Armodafinil
- ❑ Modafinil

If this is a reauthorization request, answer the following question:

Is the patient experiencing relief of fatigue with Provigil (modafinil) therapy? ❑ **Yes** ❑ **No**

Idiopathic hypersomnia:

Has the diagnosis of idiopathic hypersomnia been confirmed by a sleep study? ❑ **Yes** ❑ **No**

If a sleep study has not been completed, please provide justification confirming why a sleep study would not be feasible:

_____

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to Provigil (modafinil) therapy? ❑ **Yes** ❑ **No**

Narcolepsy:

Has the diagnosis of narcolepsy been confirmed by a sleep study? ❑ **Yes** ❑ **No**

If a sleep study has not been completed, please provide justification confirming why a sleep study would not be feasible:

_____

For brand Provigil requests, select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Amphetamine
- ❑ Amphetamine-dextroamphetamine
- ❑ Armodafinil
- ❑ Dexedrine
- ❑ Dextroamphetamine
- ❑ Dextroamphetamine extended-release (ER)
- ❑ Evekeo
- ❑ Metadate ER
- ❑ Methylin
- ❑ Methylphenidate (generic Ritalin)
- ❑ Methylphenidate chewable tablet
- ❑ Methylphenidate ER (10mg, 20mg tablets)
- ❑ Methylphenidate solution
- ❑ Modafinil
- ❑ Procentra
- ❑ Ritalin
- ❑ Zenzedi

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to prior therapy? ❑ **Yes** ❑ **No**

Provigil® (modafinil) Prior Authorization Request Form (Page 2 of 2)

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Obstructive sleep apnea/hypopnea syndrome (OSAHS):

Has the diagnosis of OSAHS been confirmed by a sleep study? ❑ **Yes** ❑ **No**

If a sleep study has not been completed, please provide justification confirming why a sleep study would not be feasible:

_____

Was the diagnosis of OSAHS defined by 15 or more obstructive respiratory events per hour of sleep? ❑ **Yes** ❑ **No**

Was the diagnosis of OSAHS defined by 5 or more obstructive respiratory events per hour of sleep AND one of these symptoms (unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring or breathing interruptions during sleep)? ❑ **Yes** ❑ **No**

For brand Provigil requests, select the medications the patient has a failure, contraindication, or intolerance to:

❑ Armodafinil ❑ Modafinil

If this is a reauthorization request, answer the following question:

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Shift work sleep disorder (SWSD):

Has SWSD been confirmed by one of the following (select from the two options below)?

❑ Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period.

❑ Sleep study demonstrating loss of a normal sleep-wake pattern (i.e., disturbed chronobiologic rhythmicity).

Has it been confirmed that no other medical condition or medication accounts for the symptoms? ❑ **Yes** ❑ **No**

For brand Provigil requests, select the medications the patient has a failure, contraindication, or intolerance to:

❑ Armodafinil ❑ Modafinil

If this is a reauthorization request, answer the following questions:

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Does the patient still require treatment for SWSD? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____

❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.