



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form**PROVIGIL (Modafinil)****Coverage Criteria**

Narcolepsy; Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS) or Shiftwork Sleep Disorder (SWSD)

Required Medical Information

Diagnosis of narcolepsy requires polysomnography. Diagnosis of OSAHS requires polysomnography and information regarding whether or not patient is using Continuous Positive Airway Pressure (CPAP).

Exclusion Criteria

Non FDA approved treatment

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

PROVIGIL	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage		
Formulary Alternative(s) Attempted?	Yes:		No:
Please List Alternative Formulary Drugs			

Comments	
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Physician Signature: _____ Fax Form to 1-877-847-9904