



NC DHB Pharmacy Request for Prior Approval Provigil and Nuvigil

Recipient Information

1. Recipient Last Name: _____ 2. First Name: _____
3. Recipient ID # _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: [] Health Choice: []

Prescriber Information

7. Prescribing Provider #: _____ NPI: [] or Atypical: []

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: [] Provigil [] Nuvigil 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): [] up to 30 [] 60 [] 90 [] 120 [] 180 [] 365 [] Other: _____

Clinical Information

- 1. Does the patient have a diagnosis of Narcolepsy? [] Yes [] No
2. Does the patient have a diagnosis of excessive sleepiness associated with shift work sleep disorder? [] Yes [] No
3. Does the patient have excessive fatigue associated with Multiple Sclerosis or Myotonic Dystonia? [] Yes [] No
4. Does the patient have a diagnosis of obstructive sleep apnea/hypopnea syndrome? [] Yes [] No
5. Does the patient use a CPAP? [] Yes [] No
6. Will Provigil/Nuvigil be used concurrently with the CPAP? [] Yes [] No
7. Is the use of a CPAP contraindicated in this patient? [] Yes [] No

Please document contraindication: _____

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318