

**NUVIGIL
Prior Authorization Form**

<input type="checkbox"/> Standard Request (72 hours) <input type="checkbox"/> Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.
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Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested: Nuvigil	Strength: <input type="checkbox"/> 50mg Tablet <input type="checkbox"/> 100mg Tablet <input type="checkbox"/> 200mg Tablet <input type="checkbox"/> 250mg Tablet	Directions:	Quantity Dispensed:	Day Supply:
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Clinical Information

<input type="checkbox"/> Narcolepsy	Please provide chart documentation of a sleep study and previous trial/failure of stimulants (such as methylphenidate, amphetamine/dextroamphetamine, dextroamphetamine).
<input type="checkbox"/> Obstructive sleep apnea/hypopnea syndrome	Please provide chart documentation of a sleep study and compliance with use of a CPAP machine.
<input type="checkbox"/> Shift work sleep disorder	Are there any other medical or mental disorders that account for the symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____ Please indicate number of over-night shifts worked per month: _____ <input type="checkbox"/> Please provide chart documentation of the shift work schedule. <input type="checkbox"/> Please provide chart documentation of a sleep study.
<input type="checkbox"/> Other	Diagnosis: _____ Date Diagnosed: _____

Please provide any additional information which should be considered in the space below:
