



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: [www.express-scripts.com/pa](http://www.express-scripts.com/pa)

Fax completed form to **1-800-357-9577**  
If this an **URGENT** request, please call 1-800-417-8164

Patient Information	
Patient First Name:	_____
Patient Last Name:	_____
Patient ID#:	_____
Patient DOB:	_____
Patient Phone #:	_____

Prescriber Information	
Prescriber Name:	_____
Prescriber DEA/NPI (required):	_____
Prescriber Phone #:	_____
Prescriber Fax #:	_____
Prescriber Address:	_____
State:	_____ Zip Code: _____

Primary Diagnosis: _____	ICD Code: _____
--------------------------	-----------------

**Please indicate which drug and strength is being requested:**

- |   |  |
|---|--|
| <input type="checkbox"/> Nuvigil 50mg Tablet  | <input type="checkbox"/> Provigil 100mg Tablet |
| <input type="checkbox"/> Nuvigil 150mg Tablet | <input type="checkbox"/> Provigil 200mg Tablet |
| <input type="checkbox"/> Nuvigil 250mg Tablet |  |

Directions for use (i.e. QD, BID, PRN & Qty): \_\_\_\_\_

Please complete the clinical assessment:			
1. What is the indication or diagnosis?			
<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Fatigue associated with HIV infection		
<input type="checkbox"/> Adjunctive/augmentation treatment of depression in adults	<input type="checkbox"/> Fatigue associated with Multiple Sclerosis (MS)		
<input type="checkbox"/> Cancer-related fatigue	<input type="checkbox"/> Fatigue or sleepiness associated with chronic use of narcotic analgesics		
<input type="checkbox"/> Excessive daytime sleepiness due to myotonic dystrophy	<input type="checkbox"/> Idiopathic hypersomnia		
<input type="checkbox"/> Excessive daytime sleepiness in Parkinsons disease	<input type="checkbox"/> Myasthenia gravis		
<input type="checkbox"/> Excessive sleepiness due to obstructive sleep apnea/hypopnea syndrome (OSAHS)	<input type="checkbox"/> Narcolepsy		
<input type="checkbox"/> Excessive sleepiness due to shift work sleep disorder (SWSD)	<input type="checkbox"/> Other: _____		
2. If the diagnosis is <u>OSAHS</u> , has the patient tried continuous positive airway pressure (CPAP)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. If the diagnosis is <u>SWSD</u> , please indicate how many overnight shifts the patient works per month: _____		<input type="checkbox"/> N/A	

<p>4. If the diagnosis is <u>fatigue or sleepiness associated with HIV infection OR chronic use of narcotic analgesics</u>, has the patient tried one CNS stimulant (for example: methylphenidate [Ritalin], dextroamphetamine [Dexedrine, Dextrostat])? If yes, please document CNS stimulant tried: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>5. If the diagnosis is <u>ADHD/ADD</u>, has the patient tried <u>two</u> alternative medications for ADHD/ADD? Alternatives must be from two different classes as follows:</p> <ol style="list-style-type: none"> <li>1. Methylphenidate products</li> <li>2. Amphetamines</li> <li>3. Strattera (atomoxetine)</li> <li>4. Wellbutrin (bupropion)</li> <li>5. TCAs (tricyclic antidepressants)</li> <li>6. Alpha-agonists (e.g., Kapvay, Intuniv)</li> </ol> <p>Please document alternative medications tried: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>6. If the diagnosis is <u>adjunctive/augmentation treatment of depression in adults</u>, is the patient concurrently receiving other medication therapy for depression? If yes, please document other drug therapy: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>7. If the diagnosis is <u>idiopathic hypersomnia</u>, has the diagnosis been confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (e.g., sleep center)?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prescriber Signature: _____	Date: _____
Office Contact Name: _____	Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.