

## 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** whether the patient is using CPAP.

### 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 1-866-481-3704**