



**Prescription Drug Coverage Determination Form**  
CNS Stimulant  
Provigil® (modafinil)

Please fax the completed form to Mercy Health Plans' Pharmacy Department  
at 314-214-8201 or 1-800-647-2240.

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Physician Information**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person \_\_\_\_\_

Physician Signature (REQUIRED): \_\_\_\_\_ Date \_\_\_\_\_

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: \_\_\_\_\_ J-code: \_\_\_\_\_  
Dose: \_\_\_\_\_ Directions: \_\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_

**Prior Authorization Criteria:**

- |  |  |
|--|--|
| 1. Does the patient have a diagnosis of narcolepsy?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes:  |  |
| ▪ Has the diagnosis of narcolepsy been confirmed with a polysomnography?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Does the patient have a diagnosis of obstructive sleep apnea/hypoapnea (OSAHS)?         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes:  |  |
| ▪ Has the diagnosis of OSAHS been confirmed with a polysomnography?                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ▪ Is the patient currently utilizing a continuous positive airway pressure (CPAP) therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ▪ Does the patient experience excessive daytime sleepiness despite optimal CPAP therapy?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ▪ Will the patient continue to use CPAP therapy?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Does the patient have a diagnosis of shift work sleep disorder (SWSD)?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes:  |  |
| ▪ Does the patient work the night shift (at least 5 hours between the hours of             | <input type="checkbox"/> Yes <input type="checkbox"/> No |

11 pm and 7 am) permanently?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| ▪ Does the patient work the night shift (at least 5 hours between the hours of 11 pm and 7 am) frequently (5 times or more per month) on a rotating basis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Does the patient experience excessive sleepiness while working?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): \_\_\_\_\_

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.