BlueCross BlueShield of North Carolina

MODAFINIL (Provigil), ARMODAFINIL (Nuvigil)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	BCBSNC PROV ID # / TAX ID [out of state only]

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP

PATIENT NAME	BCBSNC ID	DATE OF BIRTH	GENDER
			M F

Drug and Dose Requested:_____ **Dx Code:** _____ **Patient's Age:**_____

Please answer ALL the following questions:

1. For which of the following situations is modafinil or armodafinil being prescribed? *Please check at least one and answer the associated questions, if any.*

☐ **Narcolepsy -** Has this diagnosis been confirmed by a sleep study (polysomnogram and multiple sleep latency test (MSLT))?** …… ☐ Yes ☐ No

☐ **Excessive daytime sleepiness due to obstructive sleep apnea/hypopnea syndrome**
- a. Has this diagnosis been confirmed by a sleep study (polysomnogram)?** …… ☐ Yes ☐ No
- b. Will this drug be used in conjunction with continuous positive airway pressure (CPAP) therapy? ☐ Yes ☐ No
- c. If **No**, is the patient a candidate for CPAP therapy? …… ☐ Yes ☐ No

☐ **Shift-work sleep disorder (SWSD)**
- a. Is the patient a night-shift worker? …… ☐ Yes ☐ No
- b. Does the patient complain of persistent and frequent excessive sleepiness and/or falling asleep while at work, which *interferes* with the patient's work? …… ☐ Yes ☐ No

☐ **Idiopathic hypersomnolence** - Has this diagnosis been confirmed by a sleep study (polysomnogram and/or MSLT, as appropriate) to rule out disorders such as narcolepsy, obstructive sleep apnea or post-traumatic hypersomnia?**…… ☐ Yes ☐ No

☐ **Fatigue associated with multiple sclerosis**

☐ **Other** *(Medical record documentation may be required)*_____

2. Does the patient have any other conditions or drug therapies (e.g., sleeping pills) which may contribute to or worsen excessive daytime sleepiness (or night-time sleepiness for those with SWSD)? …… ☐ Yes ☐ No

3. If yes, have other conditions or drug therapies known to contribute to or worsen excessive sleepiness been addressed and/or treated? …… ☐ Yes ☐ No

4. Please list medication(s) the patient previously tried and failed, or had an inadequate response related to this diagnosis _____

_____

Please submit sleep study documentation as required above*

IF YOU ARE PRESCRIBING A QUANTITY ABOVE 2 TABLETS PER DAY OF PROVIGIL OR MODAFINIL, OR 1 TABLET PER DAY OF NUVIGIL, YOU MUST COMPLETE AND SIGN PAGE 2

Please certify the following by signing and dating below: I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required):_____Date:_____

For BCBSNC members, fax form to 1-800-795-9403

BlueCross BlueShield of North Carolina

COMPLETE PAGE 2 ONLY IF REQUESTING A QUANTITY LIMIT EXCEPTION FOR PROVIGIL, MODAFINIL OR NUVIGIL

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	BCBSNC PROV ID # / TAX ID [out of state only]

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP

PATIENT NAME	BCBSNC ID	DATE OF BIRTH	GENDER
			M F

If you are requesting a quantity above 2 tablets per day of Provigil or modafinil, or 1 tablet per day of Nuvigil, please complete the information below; otherwise, no quantity limit exception request is necessary:

Please note: This medication requires a prior authorization before a quantity limited override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (page 1). Otherwise, this request will be denied.

Dx Code: _____

Requested drug: _____

Requested quantity per day: _____
****Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)****

Medical rationale (submit records if necessary): _____

_____

_____

_____

_____

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____Date:_____

For BCBSNC members, fax form to 1-800-795-9403