UPMC HEALTH PLAN

PROVIGIL

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested: ☐Brand ☐Generic	Strength:	Frequency:	Qty Dispensed

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐New medication ☐Ongoing medication	If ongoing, provide date started:	If medication is ongoing, did member show improvement while on therapy?	☐Yes ☐No

Diagnosis:

Please indicate the diagnosis on the left and complete the corresponding questions.

Diagnosis	Questions
☐ Narcolepsy	*Please provide chart documentation of a sleep study and previous trial/failure of stimulants (such as methylphenidate, amphetamine/dextroamphetamine, dextroamphetamine, etc).*
☐ Obstructive sleep apnea/hypopnea syndrome	*Please provide chart documentation of a sleep study and compliance with use of a CPAP machine.*
☐ Shift work sleep disorder	**Please indicate number of over-night shifts worked per month:__________________** *Please provide chart documentation of the shift work schedule.* **Are there any other medical or mental disorders that account for the symptoms? If yes, please list:** ☐Yes ☐No *Please provide chart documentation of a sleep study.*
☐ Chronic fatigue due to Multiple Sclerosis	**Has member previous had a trial/failure of amantadine?** ☐Yes ☐No
☐ Other (please specify)	

HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Trial/ Previous Therapies	Date of Therapy Start Date	End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing

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