

UPMC HEALTH PLAN

Nuvigil

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: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty Dispensed (# of units):
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	

Please complete the following questions for all diagnoses.

Has the member tried and failed provigil?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for discontinuation:
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Please indicate the diagnosis on the left and complete the corresponding questions.

<input type="checkbox"/> Narcolepsy	Is the diagnosis confirmed by a sleep study? (Must Include Chart Documentation)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has member tried and failed a CNS Stimulant? (Such as Methylphenidate, Adderall, Adderall XR, Dexedrine, Concerta, Methadate CD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Shift-Work Sleep Disorder	Does the member have either a primary complaint of excessive sleepiness or insomnia which is temporarily associated with a work period (Minimum of 5 night shifts per month) that occurs during the habitual sleep phase?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is there any other Medical or Mental disorders that account for the symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes: Please explain	
<input type="checkbox"/> Obstructive Sleep Apnea	Is the diagnosis confirmed by a sleep study? (Must Include Chart Documentation)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is or has the member been using a CPAP Machine on a regular Basis? (Documentation or compliance report required)	<input type="checkbox"/> Yes <input type="checkbox"/> No

HISTORY OF FORMULARY 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:
