

# 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.*

<b>Office Contact:</b>		<b>Provider Specialty:</b>	
<b>Provider First Name:</b>		<b>Provider Last Name:</b>	
<b>Provider Phone:</b>		<b>Provider Fax:</b>	<b>Provider NPI #:</b>
<b>Patient Name:</b>	<b>Patient UPMC Health Plan ID Number:</b>	<b>Patient DOB:</b>	<b>Patient Age:</b>
<b>Drug Requested:</b> <input type="checkbox"/> Brand <input type="checkbox"/> Generic	<b>Strength:</b>	<b>Frequency:</b>	<b>Qty Dispensed</b>
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication	<b>If ongoing, provide date started:</b>	<b>If medication is ongoing, Did member Show improvement while on therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diagnosis:</b>			

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

<input type="checkbox"/> <b>Narcolepsy</b>	<i>Please provide chart documentation of a sleep study and previous trial/failure of stimulants</i>
<input type="checkbox"/> <b>Obstructive sleep apnea/hypopnea syndrome</b>	<i>Please provide chart documentation of a sleep study and use of a CPAP machine</i>
<input type="checkbox"/> <b>Shift work sleep disorder</b>	Please indicate number of over-night shifts worked per month: _____ Are there any other medical or mental disorders that account for the symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Please list:  <i>Please provide chart documentation of a sleep study</i>
<input type="checkbox"/> <b>Chronic fatigue due to Multiple Sclerosis</b>	Has member previous had a trial/failure of Amantadine? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Other (please specify)</b>	

**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:
