

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**PROVIGIL** (modafinil)

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_

Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone#: \_\_\_\_\_ Ext and options \_\_\_\_\_ Fax# \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY TO (801) 536-0477**

**CRITERIA:**

- ▶ Pt. must be age 9 years or older

**Covered for diagnosis:**

- ▶ Narcolepsy- Amphetamines or Methylphenidate must be tried first. Dose limited to 400mg qd.
- ▶ Treatment to offset sedation related to multiple sclerosis treatment modalities. Dose limited to 200mg qd.
- ▶ Daytime somnolence due to Obstructive sleep apnea, **must be on C-pap**. Dose limited to 200mg qd.
- ▶ Shift Work Sleep Disorder, **must be working night shifts**. Provide documentation of a treatment plan that demonstrates excessive sleepiness at work, insomnia when the patient should be sleeping. Patient must have a three month trial of sleep aids. Dose limited to 200mg/day.

**Authorization:**

1 year

**RE-AUTHORIZATION:**

Telephone request from physician's office or pharmacy.