



**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 INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

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

Please answer the following questions:

- 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? Yes No
 - Excessive daytime sleepiness due to obstructive sleep apnea/hypopnea syndrome**
 - Has this diagnosis been confirmed by a sleep study? Yes No
 - Will this drug be used in conjunction with continuous positive airway pressure (CPAP) therapy?.... Yes No
 - If not, is the patient a candidate for CPAP therapy?..... Yes No
 - Shift-work sleep disorder (SWSD)**
 - Is the patient a night-shift worker?..... Yes No
 - 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 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*) _____
- 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
- If yes, have other conditions or drug therapies known to contribute to or worsen excessive sleepiness been addressed and/or treated? Yes No

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

Last Revision Date: 10/1/10