Prior Authorization Form
Provigil®/Nuvigil®

TennCare

catamaran

All PA forms may be found by accessing https://tnm.providerportal.sxc.com/rxclaim/TNM/PAs.htm

If the following information is not complete, correct, or legible the PA process **can** be delayed. **Use one form per member please.**

Member Information

Last Name | **First Name**

ID Number | **Date of Birth** (– – –)

Prescriber Information

Last Name | **First Name**

NPI# | **DEA#**

Phone (– – –) | **Fax** (– – –)

REQUESTED ANTIHYPERKINESIS AGENT

☐ modafinil ☐ Nuvigil ☐ Provigil

Dose _____ **Directions** _____ **Qty** _____ **Duration of Therapy** _____

Request to Backdate PA? ☐ Yes ☐ No **If Yes, Requested PA Start Date**_____

Clinical Criteria Documentation

****Do **not** include documentation that is not requested on this form****

1. What is the diagnosis for this medication?
   ☐ Narcolepsy ☐ Obstructive sleep apnea/hypopnea syndrome
   ☐ ADD/ADHD ☐ Shift work sleep disorder ☐ Other_____
2. Has the recipient failed an adequate trial of any other stimulant agent(s)? ☐ Yes (please list) ☐ No
   Drug 1:_____ Strength: _____ Quantity: _____ Length of trial: _____
   Reason for discontinuation of the drug: _____
   Drug 2:_____ Strength: _____ Quantity: _____ Length of trial: _____
   Reason for discontinuation of the drug: _____
   Drug 3:_____ Strength: _____ Quantity: _____ Length of trial: _____
   Reason for discontinuation of the drug: _____
3. Has the recipient experienced an adverse event, or been intolerant to, a preferred stimulant? ☐ Yes ☐ No
   If yes, please list the drug (or drugs) and describe the adverse event or intolerance: _____
   _____
4. Is the patient currently taking the requested medication? ☐ Yes ☐ No
   If yes, how long has the recipient been taking the medication? _____
   How has medication been supplied (other insurance, samples provided, patient discharged from hospital on the medication, etc.)?
   _____
5. If request is for Nuvigil, has the patient tried and failed Provigil? ☐ Yes ☐ No Length of trial: _____
   If **no**, what is the reason the patient cannot take Provigil? _____
   _____

Complete this section only if diagnosis is obstructive sleep apnea/hypopnea syndrome.

6. Has the recipient had a sleep study? ☐ Yes ☐ No Date of study: _____
7. Does the provider have evidence of documented compliance with a BiPAP or CPAP device? ☐ Yes ☐ No
   Total length of therapy? _____ If no use, why?_____
   _____

----- continued on next page ----

Patient Name:_____ DOB_____

Complete this section only if diagnosis is shift work sleep disorder.

8. Does the patient work a minimum of 6 hours work between the hours of 10 pm and 8 am? ☐ Yes ☐ No

Please note any other information pertinent to this PA request: _____

_____

_____

_____

Prescriber Signature (REQUIRED):_____Date: _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Fax This Form to: 866-434-5523
Mail requests to: Catamaran PA Department, P.O. Box 3214, Lisle IL 60532-8214
Telephone 866-434-5524

Catamaran will provide a response within 24 hours day upon receipt.