Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Provigil

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Provigil.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Provigil (modafinil)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of Narcolepsy? Y N
   [If no, then skip to question 3.]

2. Is the diagnosis supported by clinical testing and a physician's interpretation of these tests confirming the diagnosis? Y N
   Please submit the physician's clinical interpretation of Multiple Sleep Latency or Maintenance of Wakefulness test. All testing should have been performed within the past 90 days.
   [No further questions.]

3. Does the patient have a diagnosis of Obstructive Sleep Apnea/Hypopnea Syndrome? Y N
   [If no, then skip to question 5.]

4. Is the diagnosis confirmed by clinical testing, a physician's interpretation of the tests supporting the diagnosis AND confirmation of the patient's concurrent use of CPAP? Y N

   Please submit the physician's clinical interpretation of either Multiple Sleep Latency/Maintenance of Wakefulness Test, or Psychomotor Vigilance Task, or Steer Clear Performance AND documentation of usage of CPAP. All testing should have been performed within the past 90 days.
   [No further questions.]

5. Does the patient have a diagnosis of Shift Work Sleep Disorder? Y N

6. Is the diagnosis confirmed by a physician's interpretation of clinical testing and documentation by the patient's supervisor of at least 10 night shifts worked out of the past 30 days? Y N

   Please submit the physician's clinical interpretation of either Multiple Sleep Latency/Maintenance of Wakefulness test AND the patient's night shift work schedule (provided by the patient's supervisor). All testing should have been performed within the past 90 days.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date