417 20th Street North Suite 1100
Birmingham, AL 35203
Fax Number: (205) 558-7506

Coverage Uses: All FDA-approved indications not otherwise excluded from Part D.
Required Information: A. Diagnosis is narcolepsy confirmed by sleep lab evaluation. OR B. Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography. OR C. Diagnosis is shift work disorder (SWD) AND patient experiences excessive sleepiness while working (works the night shift [at least 6 hours between the hours of 10pm and 8am] 5 times or more per month).
Coverage Duration: Plan Year

PROVIGIL & NUVIGIL COVERAGE DETERMINATION FORM

*****Please Note Any Incomplete or Illegible Information Will Delay the Review Process*****

Patient Information:	Prescriber Information:
Patient Name:	**Physician:**
Member ID #:	**Office Phone #:**
Date of Birth:	**Office Fax #:**
Phone #:	**DEA #:**
Address:	**Office Contact:**

Medication and Diagnosis Information:		
Medication:		**Strength:**
Route:	**Frequency:**	**Quantity:**

Coverage Criteria Questions:		
ICD Code/Diagnosis:		
1. Does the patient have the diagnosis of Circadian rhythm disruption? [If the answer to this question is yes, proceed to question 5]	**Yes**	**No**
2. Does the patient have the diagnosis of Narcolepsy? [If the answer to this question is yes, proceed to question 6]	**Yes**	**No**
3. Does the patient have the diagnosis of Sleep Apnea? [If the answer to this question is yes, proceed to question 7]	**Yes**	**No**
4. If the patient has a diagnosis not mentioned above, please explain.		
5. For a diagnosis of Circadian rhythm disruption:		
a. Does the patient work night shift (hours between 10PM and 8AM for at least 6 hours) either permanently or frequently (greater than 5 times per month)?	**Yes**	**No**
b. If YES, does the patient experience sleepiness while working? **Employer & Shift:** ____	**Yes**	**No**

6. For a diagnosis of Narcolepsy:

a. **Has the diagnosis been confirmed by a sleep lab evaluation?** **Yes** **No**
[If yes, please provide documentation of sleep study]

7. For a diagnosis of Sleep Apnea:

a. **Has the diagnosis been confirmed by a polysomnography?** **Yes** **No**
[If yes, please provide documentation of polysomnography]

Request Type:	Required Information:
☐ **Prior Authorization** *OR* ☐ **Step Therapy**	**View Prior Authorization & Step Therapy Criteria at:** www.vivamedicaremember.com/Resource/Current/Formulary.aspx
☐ **Formulary Exception:**	Request for a drug that is not on the plan's list of covered drugs. The prescriber must provide information that, given the patient's medical condition, all other medications on any tier of the formulary would not be as effective and/or would have adverse effects.
☐ **Quantity Exception:**	Request for an exception to the plan's limit on the number of pills available per month. The prescriber must provide clinical documentation that the restricted dose has been found to be ineffective and all other formulary alternatives have been found to be, or based on sound clinical judgment would likely be, ineffective.
☐ **Tier Exception:**	Request for an exception to the tier level for a covered drug. The prescriber must provide information that the drug in the lower-cost sharing tier for the treatment of the member's condition was tried and failed, is contraindicated, or would not be as effective as the drug in the higher cost-sharing tier or would have adverse effects. Limitations: Cannot request a tier exception for Tier 5 Specialty medications, or brand medications for generic tier cost-sharing, or for drugs approved as a formulary exception.

Rationale for Request: (Required)

Prescriber's Signature: **Date:**

Prescriber's Specialty:

Request for Expedited Review:

☐ By checking this box, I certify that waiting 72 hours for a standard review may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

For Urgent Requests Needed Within 24 Hours Please Provide an After-Hours Contact and Direct Phone Number: ______________________________

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