



Prescription Drug Coverage Determination Form
CNS Stimulant
Provigil® (modafinil)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: Date of Birth:
Subscriber ID#:
Address City State Zip Code

Physician Information

Name: Specialty: Tax ID#:
Office Address City State Zip Code
Telephone: Fax: Contact Person

Physician Signature (REQUIRED): Date

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: J-code:
Dose: Directions:
Expected Duration of Therapy:

Prior Authorization Criteria:

- 1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?
2. Does the patient have a diagnosis of narcolepsy?
3. Does the patient have a diagnosis of obstructive sleep apnea/hypoapnea (OSAHS)?

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.