CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Provigil**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone #:		Provider Fax #:	Provider NPI #:
Patient Name:	CCHP Member ID #:	Patient DOB:	Patient Age:
Drug Requested: **Brand** **Generic**	Strength:	Frequency:	Quantity Dispensed (including units):

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	☐ **Yes** ☐ **No**
Diagnosis:		Date of Diagnosis:	

Please indicate the diagnosis on the left and complete the corresponding questions.

Narcolepsy	Please provide chart documentation of a sleep study and previous trial/failure of stimulants (such as methylphenidate, amphetamine/dextroamphetamine, dextroamphetamine, etc).
Obstructive sleep apnea/hypopnea syndrome	Please provide chart documentation of a sleep study and compliance with use of a CPAP machine.
Shift work sleep disorder	Please indicate number of over-night shifts worked per month: Please provide chart documentation of the shift work schedule. Are there any other medical or mental disorders that account for the symptoms? ☐ Yes ☐ No If yes, please list: Please provide chart documentation of a sleep study.
Chronic fatigue due to Multiple Sclerosis	Has member previous had a trial/failure of amantadine? ☐ Yes ☐ No
Other (please specify)	

History of previous medications used to treat the above condition

Medication	Strength	Frequency	Start date	End date	Reason for failure or discontinuation
Please provide any additional clinical information which should be considered in the space below:					