NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

NC DHB Pharmacy Request for Prior Approval Provigil and Nuvigil

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: ☐ Provigil ☐ Nuvigil 10. Strength: _____11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_____

Clinical Information

1. Does the patient have a diagnosis of Narcolepsy? ☐ Yes ☐ No
2. Does the patient have a diagnosis of excessive sleepiness associated with shift work sleep disorder? ☐ Yes ☐ No
3. Does the patient have excessive fatigue associated with Multiple Sclerosis or Myotonic Dystonia? ☐ Yes ☐ No
4. Does the patient have a diagnosis of obstructive sleep apnea/hypopnea syndrome? ☐ Yes ☐ No
5. Does the patient use a CPAP? ☐ Yes ☐ No
6. Will Provigil/Nuvigil be used concurrently with the CPAP? ☐ Yes ☐ No
7. Is the use of a CPAP contraindicated in this patient? ☐ Yes ☐ No

Please document contraindication: _____
_____

Signature of Prescriber:_____ Date:_____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**