

Provigil (modafinil) / Nuvigil (armodafinil)



An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Request (Physician to Complete)

Facsimile Transmittal Sheet	Date: ____ / ____ / ____
To: <u>Wellmark Pharmacy Services</u>	From (Prescriber's Name): _____
Fax Number: <u>(866) 884-4345</u>	Prescriber's DEA Number: _____
Phone Number: <u>(800) 600-8065</u>	Prescriber's Phone Number: _____
Prescriber's Specialty: _____	Prescriber's Fax Number: _____
Prescriber's Office Address: _____	
Street	Suite # City State Zip
Patient Name: _____	
Patient ID: _____	Patient DOB: ____ / ____ / ____

Thank you for taking the time to provide clinical information to ensure appropriate drug therapy for your patient. Please answer the following questions and fax this form back to (866) 884-4345.

1. Please provide the diagnosis this therapy has been prescribed for: _____

ICD-9 Code: _____

2. Drug Strength: _____ mg Quantity/30 days: _____ units

Directions: _____

3. Is the patient currently using CPAP therapy? Yes No

4. Does the patient have a diagnosis of narcolepsy? Yes No

Refer to the Wellmark Drug List on www.wellmark.com for current medication tier levels

Printed Name

Signature

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