

**PRIOR AUTHORIZATION REQUEST FORM**

**EOC ID:**

**EIC provigil**



**Phone: 866-250-2005 Fax back to: 877-503-7231**

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

**Patient Name:**

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

**Prescriber Name:**

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:**

Q1. Diagnosis/Indication:a) Narcolepsyb) Obstructive sleep apnea/hypopnea syndrome (OSAHS)c) Shift Work Sleep Disorder (SWSD)d) Other

- a) Narcolepsy
- b) Obstructive sleep apnea/hypopnea syndrome (OSAHS)
- c) Shift Work Sleep Disorder (SWSD)
- d) Other

Q2. If the diagnosis is Other, then please submit further information below.

Q3. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support your request for off-label use. Please attach any medical information that may support approval

**Physician Signature**

**Date**