

Health New England
Medication Request Form (MRF)
Provigil® (modafinil)

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|--|
| DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY |
| Contacted: |
| Physician: |
| Pharmacy: |
| Patient: |
| |
| |

Prior Authorization

| |
|--|
| DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY |
| Approved: |
| Quantity approved: |
| PA from and thru date: |
| PA # |
| Denied: |
| Returned: |

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Provigil®. Please complete this form and fax to MedMetrics Health Partners at (800) 550-9246. If you have any questions regarding this process, please contact MedMetrics clinical call center at (866) 209-1057.

Medication Request Information (please complete each section of this form prior to transmittal):

| Patient Information | Physician Information |
|--|---|
| Patient Name (required): | Physician Name: |
| | Specialty: |
| Patient HNE ID# (required): | HNE Provider #: |
| Patient Date of Birth (required): | DEA # (required): |
| Allergies: | Area Code and Telephone #: () - |
| | Area Code and Fax # (required): () - |

| Drug Information | | |
|---|------------------------------|-----------------|
| Requested Drug / Strength: | Provigil® | |
| Dose, directions and length of treatment (please be specific): | Quantity (per month): | Refills: |
| Physician signature: | Date: | |
| Indication: | | |
| <input type="checkbox"/> Narcolepsy. <input type="checkbox"/> Fatigue associated with Multiple Sclerosis (MS). <input type="checkbox"/> Shift work sleep disorder <input type="checkbox"/> Obstructive sleep apnea/hypopnea with utilization of CPAP <input type="checkbox"/> Other (please describe): _____ _____ _____ _____ | | |