

**Request Form for modafinil (Provigil®)]**

**Physician Information**

Name: \_\_\_\_\_  
# License: \_\_\_\_\_ Physician specialty: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Patient Information**

**General Information:**

Name: \_\_\_\_\_ Member ID: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Address: \_\_\_\_\_  
Sex:  M  F Weight: \_\_\_\_\_

**Medication requested:**

Name: \_\_\_\_\_ Dose: \_\_\_\_\_

**Medical Information**

*Please answer the following questions:*

1) The patient presents the following diagnosis:  
Please select

- Narcolepsy
- Obstructive sleep apnea
- Shift work sleep disorder

2) Please provide current therapies for obstructive sleep apnea-hypopnea syndrome (OSAHS)

Drug: \_\_\_\_\_ Dates: \_\_\_\_\_  
Drug: \_\_\_\_\_ Dates: \_\_\_\_\_  
Drug: \_\_\_\_\_ Dates: \_\_\_\_\_

3) Is the patient currently using CPAP therapy?

Yes  No

Please provide any medical information which may support approval: (optional)

Physician signature: \_\_\_\_\_

Date: \_\_\_\_\_