**Criteria for Approval:** (Provigil=Patient must be age 9 years or older; Nuvigil=Patient must be age 17 years or older)

**Provigil covered for the following diagnoses:**
- Narcolepsy: Dose limited to 400mg/day
  - Trial/Failure for at least 3 months of at least one Amphetamine(s) or Methylphenidate.
  - Medication Used: ______________________
  - Details of Failure: ______________________
  - Chart Note Page #: ______________________
- Treatment to offset sedation related to multiple sclerosis treatment modalities. Dose limited to 200mg/day
- Daytime somnolence due to Obstructive sleep apnea, must be on C-pap. Dose limited to 200mg/day.
- Shift Work Sleep Disorder: Dose limited to 200mg/day
  - *must be working night shifts*
  - Provide documentation of a treatment plan that demonstrates excessive sleepiness at work, insomnia when the patient should be sleeping

**Nuvigil covered for the following diagnoses:**
- Narcolepsy: Dose limited to 250mg/day
  - Trial/Failure for at least 3 months of at least one Amphetamine(s) or Methylphenidate.
  - Medication Used: ______________________
  - Details of Failure: ______________________
  - Chart Note Page #: ______________________
- Daytime somnolence due to Obstructive sleep apnea, must be on C-pap. Dose limited to 150mg/day.
- Shift Work Sleep Disorder: Dose limited to 150mg/day
  - *must be working night shifts*
  - Provide documentation of a treatment plan that demonstrates excessive sleepiness at work, insomnia when the patient should be sleeping

**Re-authorization Criteria:**
- Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.
- For daytime somnolence due to Obstructive sleep apnea, patient should continue on CPAP or explain why CPAP has been discontinued.
- For Shift Work Sleep Disorder, patient should still be working night shifts.

**Notes:**
Provigil and Nuvigil are mutually exclusive. Patients may only have a prior authorization for one of these medications at a time.

**Initial Authorization:** up to 6 months
**Re-authorization:** Up to 1 year

**PROVIDER CERTIFICATION**
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber’s Signature ______________________
Date ______________________