



Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ()	
BCBSLA Provider Number	Area of Practice/Specialty	Name of Place of Treatment	Treatment Center Provider #	Phone Number ()	
BILLING DATA	Diagnosis Code(s) (ICD-9): 1) 2)		CPT-4/HCPCS Code	Other Codes	

DRUG INFORMATION - Nuvigil/Provigil

NUVIGIL® PROVIGIL®

INDICATION / DIAGNOSIS

<input type="checkbox"/> ADHD/ADD <input type="checkbox"/> Adjunctive/augmentation treatment of depression in adults <input type="checkbox"/> Adjunctive treatment for schizophrenia <input type="checkbox"/> Alcoholic organic brain syndrome <input type="checkbox"/> Bipolar disorder, including bipolar depression <input type="checkbox"/> Cancer-related fatigue <input type="checkbox"/> Chronic fatigue syndrome <input type="checkbox"/> Enhancement of performance in situations that induce sleep deprivation <input type="checkbox"/> Excessive daytime sleepiness due to myotonic dystrophy <input type="checkbox"/> Excessive daytime sleepiness in Parkinson's disease	<input type="checkbox"/> Excessive daytime sleepiness associated with primary insomnia <input type="checkbox"/> Excessive sleepiness due to obstructive sleep apnea/hypopnea syndrome (OSAHS) <input type="checkbox"/> Excessive sleepiness due to shift work sleep disorder (SWSD) <input type="checkbox"/> Fatigue or sleepiness associated with chronic use of narcotic analgesics <input type="checkbox"/> Fatigue associated with HIV infection <input type="checkbox"/> Fatigue and excessive daytime sleepiness due to chronic traumatic brain injury <input type="checkbox"/> Fatigue associated with multiple sclerosis (MS)	<input type="checkbox"/> Fatigue in post-polio patients <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Hypersomnia (diagnosed by someone other than a sleep specialist), fatigue or sleepiness due to other specific conditions or of unknown etiology <input type="checkbox"/> Idiopathic Hypersomnia (diagnosed by a sleep specialist) <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Seasonal affective disorder <input type="checkbox"/> Spasticity due to cerebral palsy <input type="checkbox"/> Post-stroke sleep-wake disorders (SWD) or sleep disorders <input type="checkbox"/> Other:
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OTHER CLINICAL INFORMATION (Check ALL that apply)

<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried continuous positive airway pressure (CPAP)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient work 5 or more overnight shifts per month? Quantity of overnight shifts per month: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient currently taking medications for depression? If yes, specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried one CNS stimulant? If yes, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried two alternative medications for ADHD/ADD? If yes, specify: _____ List any other relevant clinical info if applicable: _____
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DRUG INFORMATION- Seroquel

SEROQUEL® Dose and Frequency: _____

INDICATION / DIAGNOSIS

<input type="checkbox"/> Augmentation therapy in the treatment of depression, Obsessive-Compulsive Disorder (OCD), Post Traumatic Stress Disorder (PTSD), or anxiety.	<input type="checkbox"/> Delirium <input type="checkbox"/> Insomnia <input type="checkbox"/> Pain	<input type="checkbox"/> Tourette's disorder <input type="checkbox"/> Treatment or prevention of Headache <input type="checkbox"/> Other:
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OTHER CLINICAL INFORMATION (Check ALL that apply)

<input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient's dose of Seroquel less than or equal to 100 mg per day? If yes, specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescriber a Psychiatrist or Neurologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No Patient is currently taking an oral or injectable antipsychotic; specify _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is currently taking a mood stabilizer; specify _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Patient is currently taking an anti-Parkinson's disease medication; specify _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is currently taking an anti-dementia medication; specify _____
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PHYSICIAN SIGNATURE

DATE

Prescribing Physician

DATE

Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed