

**PROVIGIL® / NUVIGIL™**  
**PREAUTHORIZATION REQUEST**  
**PHYSICIAN FAX FORM**



**BlueCross BlueShield  
of Illinois**

**ONLY the prescriber may complete and fax this form.**

**Incomplete forms will be returned for additional information.** The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit [www.bcbsil.com](http://www.bcbsil.com)

**Today's Date:** \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:		City, State, Zip	Patient Telephone:

**INSURANCE INFORMATION**

BCBS ID Number:	Group Number:
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**PHYSICIAN/CLINIC INFORMATION**

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's Diagnosis - ICD-9 code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p>1. Is the patient currently treated with the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes: -When was treatment with the requested medication started? _____</p> <p>-Is this request for a higher dose because the patient is inadequately treated with a lower dose of the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Please list all reasons for selecting the <b>requested medication</b> over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____</p> <p>_____</p> <p>_____</p> <p>3. Please list all other medications the patient is <b>currently taking</b> for treatment of this diagnosis. _____</p> <p>_____</p> <p>_____</p> <p>4. Please list all medications the patient has <b>previously tried and failed</b> for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____</p> <p>_____</p> <p>_____</p>	

**Please fax or mail this form to:**  
Blue Cross and Blue Shield of Illinois  
c/o Prime Therapeutics LLC, Clinical Review Department  
1305 Corporate Center Drive  
Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130      Phone: 800.285.9426**

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