



An Independent Licensee  
of the Blue Cross and  
Blue Shield Association

## Precertification Request Form for **Nuvigil®**

**Precertification for Nuvigil® requires completion of this form in its entirety.** All requested data must be provided. Once completed the form must be signed by the medical provider and faxed back to BCBSAZ Pharmacy Management at **(602) 864-3126**. Incomplete forms may result in denial of requested medication due to lack of needed information.

Provider Information			Patient Information		
Physician's Name			Patient's Name		
Physician Specialty	NPI #		BCBSAZ Member ID		
Mailing Address			Date of Birth / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
City	State	Zip Code	Patient's Address		
Phone # ( ) - ext	Fax # ( ) -		City	State	Zip Code

Medication Information	
Medication Name & Strength:	_____
Directions for Use & Duration:	_____
Diagnosis Code:	_____
Diagnosis:	_____

**All of the following questions and/or information must be answered and provided to assess request:  
(Office notes are not needed if all information has been provided unless otherwise stated)**

Excessive sleepiness is associated with following diagnosis:		
Yes	No	
		Narcolepsy
		Obstructive sleep apnea in an individual on continuous positive airway pressure (CPAP) therapy <b>(last 2 most recent physician office notes are required that show continuous use of CPAP)</b>
		Shift Work Sleep Disorder (individual with complaints of persistent and frequent excessive sleepiness and/or falling asleep while at work and is not receiving other drugs or does not have a medical condition known to cause or contribute to sleepiness) <b>(last 2 most recent physician office notes are required that outline treatment plan for Shift Work Sleep Disorder)</b>

**Signature affirms that information given on this form is true and accurate and reflects office notes**

Physician's Signature	Date
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