Prior Authorization Approval Criteria

Provigil (modafinil)

Generic Name: modafinil
Brand Name: Provigil
Medication Class: antinarcoleptic
FDA Approved Uses: Narcolepsy
Shift Work Sleep Disorders (SWSD)
Adjunct to standard treatments for Obstructive Sleep Apnea (OSA)
Other Uses: Fatigue due to Multiple Sclerosis (MS)

Criteria for approval for all indications:
- Must be prescribed by or recommended by a neurologist, psychiatrist, sleep medicine specialist or pulmonary specialist
- Must be at least 18 years old

Criteria for approval: Narcolepsy: (bullet points below are all inclusive unless otherwise noted)
- Clinically diagnosed narcolepsy
- Failure/ intolerance or contraindication to at least one formulary/preferred treatment, such as methylphenidate or dextroamphetamine,

Criteria for Approval: SWSD (bullet points below are all inclusive unless otherwise noted)
- Clinically diagnosed shift work sleep disorder.

Criteria for Approval: OSA (bullet points below are all inclusive unless otherwise noted)
- Clinically diagnosed obstructive sleep apnea
- Patient has been compliant with continuous positive airway pressure (CPAP) for at least 2 months

Criteria for Approval: Fatigue due to MS (bullet points below are all inclusive unless otherwise noted)
- Clinically diagnosed multiple sclerosis.
- Other causes for fatigue have been ruled out such as poor nighttime sleep patterns.
- Failure/ intolerance or contraindication to at least one of the following: amantadine, dextroamphetamine-amphetamine, lisdexamfetamine, or methylphenidate

Criteria for continuation of therapy:
- Patient’s therapy has been re-evaluated within the last 12 months, unless a re-evaluation is not clinically appropriate for the patient’s condition at this time.
- Patient is tolerating treatment and there continues to be a medical need for the medication
  Patient has disease stabilization or improvement in disease (as defined by standard parameters for the patient’s condition)

Criteria for quantities over 1 per day:
- Must have a clinically documented medical need for the increased quantity (including, but not limited to, increased dose, frequency, or duration).
- Must have tried and failed the standard approved dosing, frequency, and duration.

Approval duration:
- 12 months
Benefit Type:
  • Pharmacy

Adopted: 11/8/04
Revised: 1/25/13, 8/26/13
Reviewed: 6/14/17 - updated criteria for use, continuation of therapy, removed contraindications and not approved if sections, added approval duration & benefit type