DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00079 (01/2019)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR ARMODAFINIL AND MODAFINIL

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Armodafinil and Modafinil Instructions, F-00079A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Armodafinil and Modafinil form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Member ID Number

3. Date of Birth – Member

SECTION II – PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Directions for Use

8. Refills

9. Name – Prescriber

10. National Provider Identifier (NPI) – Prescriber

11. Address – Prescriber (Street, City, State, Zip+4 Code)

12. Phone Number – Prescriber

SECTION III – CLINICAL INFORMATION

13. Diagnosis Code and Description

SECTION III A – CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA HYPOPNEA SYNDROME (OSAHS)

14. Does the member have OSAHS? ☐ Yes ☐ No

If yes, complete the remainder of Section III A.
If no, proceed to Section III B, Element 18.

15. Has the member had an overnight polysomnogram (PSG) sleep study with an Apnea-Hypopnea Index (AHI) greater than or equal to five events per hour? ☐ Yes ☐ No

Indicate the member's AHI: _____ events per hour.

Continued

SECTION III A – CLINICAL INFORMATION FOR OSAHS (Continued)

16. Is the member taking any other stimulants or related agents? ☐ Yes ☐ No

17. Has the member tried continuous positive airway pressure (CPAP)? ☐ Yes ☐ No

If requested by ForwardHealth, the provider is required to submit the test results and provider interpretation for the PSG.

SECTION III B – CLINICAL INFORMATION FOR NARCOLEPSY

18. Does the member have narcolepsy? ☐ Yes ☐ No

If yes, complete the remainder of Section III B.
If no, proceed to Section III C, Element 22.

19. Has the member had an overnight PSG sleep study followed by a multiple sleep latency test (MSLT) that confirm the member has narcolepsy? ☐ Yes ☐ No

If yes, provide responses to the following questions regarding the PSG and MSLT sleep studies:

PSG

A. Was the member's total sleep time less than 360 minutes? ☐ Yes ☐ No

B. Did the member experience significant sleep interruptions (for example, respiratory events, periodic leg movements)? ☐ Yes ☐ No

C. Did the provider interpretation indicate the member had an adequate night's sleep? ☐ Yes ☐ No

MSLT

D. Was the MSLT conducted the morning after the overnight PSG? ☐ Yes ☐ No

E. Was the average sleep latency for all naps greater than eight minutes? ☐ Yes ☐ No

F. Indicate the number of sleep onset rapid eye movement periods (SOREMPs) the member achieved during the MSLT. _____ SOREMPs

0 = No SOREMPs 1 = One SOREMP 2 = Two or more SOREMPs

If requested by ForwardHealth, the provider is required to submit the test results and provider interpretation for the PSG and MSLT, along with medical record documentation supporting a clinical correlation between the test results and a diagnosis of narcolepsy.

20. Is the member taking any sedative hypnotics? ☐ Yes ☐ No

21. Is the member taking central nervous system (CNS) depressants (for example, anxiolytics, barbiturates, or opioids)? ☐ Yes ☐ No

If yes, indicate the CNS depressants and daily doses.

1.

2.

3.

Are any of the above listed CNS depressants contributing to the member's daytime sleepiness? ☐ Yes ☐ No

If no, indicate how the prescriber evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.

Continued

SECTION III C – CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

22. Does the member have shift work sleep disorder? ☐ Yes ☐ No

    If yes, complete the remainder of Section III C.
    If no, proceed to Section III D, Element 27.

23. Is the member a night-shift worker? ☐ Yes ☐ No

    If yes, indicate the member's current employer and weekly work schedule.

24. Is the member taking any sedative hypnotics? ☐ Yes ☐ No

25. Is the member taking CNS depressants (for example, anxiolytics, barbiturates, or opioids)? ☐ Yes ☐ No

    If yes, indicate the CNS depressants and daily doses.

    1.

    2.

    3.

    Are any of the above listed CNS depressants contributing to the member's daytime sleepiness? ☐ Yes ☐ No

    If no, indicate how the prescriber evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.

26. Is the member taking any other stimulants or related agents? ☐ Yes ☐ No

SECTION III D – CLINICAL INFORMATION FOR ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) (Complete this section only for PA requests for modafinil, if applicable.)

27. Does the member have a diagnosis of ADHD? ☐ Yes ☐ No

28. Is the member taking any other stimulants or related agents? ☐ Yes ☐ No

29. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with **at least two** preferred stimulants? ☐ Yes ☐ No

    If yes, indicate the preferred stimulants and doses, specific dates about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates each preferred stimulant was taken in the space provided.

    1.

    2.

    3.

    4.

Continued

SECTION III D – CLINICAL INFORMATION FOR ADHD (Complete this section only for PA requests for modafinil, if applicable.) (Continued)

30. Has the member previously taken atomoxetine and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? ☐ Yes ☐ No

31. Does the member have a medical history of substance abuse disorder? ☐ Yes ☐ No

32. Does the member have a serious risk of drug diversion? ☐ Yes ☐ No

SECTION IV – AUTHORIZED SIGNATURE

33. **SIGNATURE** – Prescriber	34. Date Signed

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

35. National Drug Code (11 Digits)	36. Days' Supply Requested (Up to 365 Days)

37. NPI

38. Date of Service (mm/dd/ccyy) (For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.)

39. Place of Service

40. Assigned PA Number

41. Grant Date	42. Expiration Date	43. Number of Days Approved

SECTION VI – ADDITIONAL INFORMATION

44. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

Reset Form