FORWARDHEALTH

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

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is only used for purposes directly related to ForwardHealth administration, such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting a PA for certain drugs. Attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS
Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Armodafinil and Modafinil, F-00079. Pharmacy providers are required to use the PA/PDL for Armodafinil and Modafinil form to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a PA request on the ForwardHealth Portal, by fax, or by mail. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Pharmacy providers may submit PA requests on a PA/PDL form in one of the following ways:

- For STAT-PA requests, pharmacy providers should call 800-947-1197.
- For requests submitted on the ForwardHealth Portal, pharmacy providers may access www.forwardhealth.wi.gov/.
- For PA requests submitted by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA/PDL form to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL to the following address:

  ForwardHealth
  Prior Authorization
  Ste. 88
  313 Blettner Blvd.
  Madison, WI 53784

Providers and prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I – MEMBER INFORMATION

Element 1: Name – Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth ID card and the EVS do not match, use the spelling from the EVS.

Element 2: Member ID Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Element 3: Date of Birth – Member
Enter the member's date of birth in mm/dd/ccyy format.

SECTION II – PRESCRIPTION INFORMATION
Providers should check only the name and strength of the drug for which PA is being requested.

Element 4: Drug Name
Enter the name of the drug.

Element 5: Drug Strength
Enter the strength of the drug in milligrams.

Element 6: Date Prescription Written
Enter the date that the prescription was written.

Element 7: Directions for Use
Enter the directions for use of the drug.

Element 8: Refills
Enter the number of refills.

Element 9: Name – Prescriber
Enter the name of the prescriber.

Element 10: National Provider Identifier (NPI) – Prescriber
Enter the prescribing provider's NPI for prescriptions for non-controlled substances.

Element 11: Address – Prescriber
Enter the address (street, city, state, and zip+4 code) of the prescribing provider.

Element 12: Phone Number – Prescriber
Enter the telephone number, including area code, of the prescribing provider.

SECTION III – CLINICAL INFORMATION
Prescribers are required to complete Section III and either Section III A, III B, III C, or III D before signing and dating the PA/PDL for Armodafinil and Modafinil form.

Element 13: Diagnosis Code and Description
Enter the appropriate and most specific *International Classification of Diseases* (ICD) diagnosis code and description most relevant to the drug requested. The ICD diagnosis code must correspond with the ICD description.

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

Element 14
Check the appropriate box to indicate whether or not the member has OSAHS. If yes, complete the remainder of Section III A. If no, proceed to Section III B, Element 18.

Element 15
Check the appropriate box to indicate whether or not the member has had an overnight polysomnogram (PSG) sleep study with an Apnea-Hypopnea Index (AHI) greater than or equal to five events per hour. Indicate the member's AHI in the space provided.

Element 16
Check the appropriate box to indicate whether or not the member is taking any other stimulants or related agents.

Element 17
Check the appropriate box to indicate whether or not the member has tried continuous positive airway pressure (CPAP).

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

Element 18
Check the appropriate box to indicate whether or not the member has narcolepsy. If yes, complete the remainder of Section III B. If no, proceed to Section III C, Element 22.

Element 19
Check the appropriate box to indicate whether or not the member has had an overnight PSG sleep study followed by a multiple sleep latency test (MSLT) that confirm the member has narcolepsy. If yes, respond to the following questions on the form regarding PSG and MSLT sleep studies.

PSG
A. Was the member's total sleep time less than 360 minutes?
B. Did the member experience significant sleep interruptions (for example, respiratory events, periodic leg movements)?
C. Did the provider interpretation indicate that an adequate night's sleep was achieved?

MSLT
D. Was the MSLT conducted the morning after the overnight PSG?
E. Was the average sleep latency for all naps greater than eight minutes?
F. Indicate the number of sleep onset rapid eye movement periods (SOREMPs) the member achieved during the MSLT (0 = no SOREMPs, 1 = one SOREMP, 2 = two or more SOREMPs).

If requested by ForwardHealth, the provider must 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.

Element 20
Check the appropriate box to indicate whether or not the member is taking any sedative hypnotics.

Element 21
Check the appropriate box to indicate whether or not the member is taking central nervous system (CNS) depressants (for example, anxiolytics, barbiturates, or opioids). If yes, indicate the CNS depressants and daily doses in the spaces provided on the form. Indicate whether or not any of the listed CNS depressants contribute to the member's daytime sleepiness. If not, indicate how the prescriber evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.

SECTION III C – CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

Element 22
Check the appropriate box to indicate whether or not the member has shift work sleep disorder. If yes, complete the remainder of Section III C. If no, proceed to Section III D, Element 27.

Element 23
Check the appropriate box to indicate whether or not the member is a night-shift worker. If yes, indicate the member's employer and weekly work schedule.

Element 24
Check the appropriate box to indicate whether or not the member is taking any sedative hypnotics.

Element 25
Check the appropriate box to indicate whether or not the member is taking any CNS depressants (for example, anxiolytics, barbiturates, or opioids). If yes, indicate the CNS depressants and daily doses in the spaces provided on the form. Indicate whether or not any of the listed CNS depressants contribute to the member's daytime sleepiness. If not, indicate how the prescriber evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.

Element 26
Check the appropriate box to indicate whether or not the member is taking any other stimulants or related agents.

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

Element 27
Check the appropriate box to indicate whether or not the member has a diagnosis of ADHD.

Element 28
Check the appropriate box to indicate whether or not the member is taking any other stimulants or related agents.

Element 29
Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least **two** preferred stimulants. 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.

Element 30
Check the appropriate box to indicate whether or not the member has previously taken atomoxetine and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

Element 31
Check the appropriate box to indicate whether or not the member has a medical history of substance abuse disorder.

Element 32
Check the appropriate box to indicate whether or not the member poses a serious risk of drug diversion.

SECTION IV – AUTHORIZED SIGNATURE

Element 33: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 34: Date Signed
Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

Element 35: National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 36: Days' Supply Requested
Enter the requested days' supply, up to 365 days.

Element 37: NPI
Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

Element 38: Date of Service
Enter the requested first date of service (DOS) for the drug in mm/dd/ccyy format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 39: Place of Service
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Code	Description
01	Pharmacy
13	Assisted living facility
14	Group home
32	Nursing facility
34	Hospice
50	Federally qualified health center
65	End-stage renal disease treatment facility
72	Rural health clinic

Element 40: Assigned PA Number
Enter the PA number assigned by the STAT-PA system.

Element 41: Grant Date
Enter the date the PA request was approved by the STAT-PA system.

Element 42: Expiration Date
Enter the date the PA expires as assigned by the STAT-PA system.

Element 43: Number of Days Approved
Enter the number of days for which the PA request was approved by the STAT-PA system.

SECTION VI – ADDITIONAL INFORMATION

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