

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MODAFINIL AND NUVIGIL®

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Modafinil and Nuvigil® Completion 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 Drug Attachment for Modafinil and Nuvigil® form signed by the prescriber before submitting a prior authorization (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 Identification 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 — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

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 this form.)

13. Diagnosis Code and Description

14. Is the member 16 years of age or older?

Yes No

15. Is the member taking any other stimulants or related agents?

Yes No

SECTION III A — CLINICAL INFORMATION FOR NARCOLEPSY WITH CATAPLEXY OR WITHOUT CATAPLEXY

16. Does the member have narcolepsy with cataplexy or without cataplexy?

Yes No

17. Has the member had an overnight polysomnogram (PSG) sleep study followed by a multiple sleep latency test (MSLT)?

Yes No

The results from the PSG and MSLT, along with provider interpretation, *must* be submitted with this PA request for consideration.

Continued



DT-PA082-082

SECTION III A — CLINICAL INFORMATION FOR NARCOLEPSY (Continued)

18. Is the member taking any sedative hypnotics? Yes No

19. Is the member taking central nervous system (CNS) depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness? Yes No

If yes, indicate the CNS depressants and daily doses.

1. _____
2. _____
3. _____

SECTION III B — CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA / HYPOPNEA SYNDROME (OSAHS)

20. Does the member have OSAHS? Yes No

21. Has the member had an overnight PSG sleep study? Yes No

The results from the PSG, along with the provider interpretation, *must* be submitted with this PA request for consideration.

22. What is the member's Apnea-Hypopnea Index (AHI)? _____ Events / Hour

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

SECTION III C — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

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

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

26. Indicate the member's current employer and weekly work schedule.

27. Is the member taking any sedative hypnotics? Yes No

28. Is the member taking CNS depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness? Yes No

If yes, indicate the CNS depressants and daily doses.

1. _____
2. _____
3. _____

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

29. Does the member have a diagnosis of ADD or ADHD? Yes No

30. 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 details 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 ADD OR ADHD (Continued) (Complete this section only for PA requests for modafinil, if applicable.)

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

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates Strattera was taken in the space provided.

32. Does the member have a medical history of substance abuse or misuse? Yes No

If yes, explain in the space provided.

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

If yes, explain in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

34. SIGNATURE — Prescriber

35. Date Signed

SECTION V — ADDITIONAL INFORMATION

36. 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.