**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? ☐ Yes ☐ No

If yes, indicate in the space below the cataplexy symptoms experienced by the member and how frequently they occur.

17. Does the member have narcolepsy without cataplexy? ☐ Yes ☐ No

*Continued*

**SECTION III A – CLINICAL INFORMATION FOR NARCOLEPSY WITH CATAPLEXY OR WITHOUT CATAPLEXY (Continued)**

18. Has the member had an overnight polysomogram (PSG) sleep study followed by a multiple sleep latency test (MSLT)? ☐ Yes ☐ No

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, **must** be submitted with this PA request for consideration.

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

20. Is the member taking central nervous system (CNS) depressants (i.e., 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.

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

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

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

Test results and provider interpretation for the PSG **must** be submitted with this PA request for consideration.

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

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

**SECTION III C – CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER**

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

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

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

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

*Continued*

**SECTION III C – CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER (Continued)**

29. Is the member taking CNS depressants (i.e., 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.

**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.)**

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

31. 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. _____

32. 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.

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

If yes, explain in the space provided.

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

If yes, explain in the space provided.

*Continued*

| **SECTION IV – AUTHORIZED SIGNATURE** | |
|---|---|
| 35. **SIGNATURE** – Prescriber | 36. Date Signed |

**SECTION V – ADDITIONAL INFORMATION**

37. 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