

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. Providers may call Provider Services at (800) 947-9627 with questions.

Nuvigil® is not covered for BadgerCare Plus Core Plan members.

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. Modafinil Drug Strength (Check one only. If a box is checked in this element, do not check a box in Element 5.)

100 mg 200 mg

5. Nuvigil® Drug Strength (Check one only. If a box is checked in this element, do not check a box in Element 4.)

50 mg 150 mg 250 mg

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 (Providers are required to complete Section III and either Section IIIA, IIIB, IIIC, or IIID before signing and dating this form.)

13. Diagnosis Code and Description

14. Is the member at least 16 years old?

Yes No

15. Is the member taking any other stimulants?

Yes No

16. For requests for Nuvigil®: Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to modafinil?

(If the request is for modafinil, check "N/A.")

Yes No N/A

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

SECTION IIIA — CLINICAL INFORMATION FOR NARCOLEPSY

17. Does the member have a diagnosis of narcolepsy?

Yes No

18. Has the member had a polysomnogram (PSG)?

Yes No

Continued



SECTION IIIA — CLINICAL INFORMATION FOR NARCOLEPSY (Continued)

19. Has the member had a multiple sleep latency test (MSLT)? Yes No

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

SECTION IIIB — CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA / HYPOPNEA SYNDROME

20. Does the member have a diagnosis of obstructive sleep apnea / hypopnea syndrome (OSAHS)? Yes No

21. Has the member had a PSG? Yes No

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

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

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

SECTION IIIC — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

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

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

26. Is the member taking any hypnotics, sleep aids, or other medications that can cause sleepiness? Yes No

27. State the member's employer and weekly work schedule.

SECTION IIID — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER (Complete this section only for PA requests for modafinil.)

28. Does the member have a diagnosis of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)? 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, list the preferred stimulants and doses, specific details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates the preferred stimulants were taken in the space provided.

1. _____
2. _____
3. _____
4. _____

30. 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.

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

If yes, explain in the space provided.

SECTION IIID — CLINICAL INFORMATION FOR ATTENTION DEFICIT DISORDER (Continued)

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

If yes, explain in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

33. SIGNATURE — Prescriber

34. Date Signed

SECTION V — ADDITIONAL INFORMATION

35. 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.