

## FORWARDHEALTH PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MODAFINIL AND NUVIGIL® COMPLETION INSTRUCTIONS

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

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

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is 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. If necessary, 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

Attach the completed Prior Authorization Drug Attachment for Modafinil and Nuvigil® form, F-00079, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers may submit PA requests on paper by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
313 Blettner Blvd  
Madison WI 53784

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

*Note:* Nuvigil® is not covered by the BadgerCare Plus Core Plan.

### 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 identification card and the EVS do not match, use the spelling from the EVS.

#### Element 2 — Member Identification 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 — Modafinil Drug Strength

Check the strength of drug in milligrams.

#### Element 5 — Nuvigil® Drug Strength

Check the strength of 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 — Prescriber**

Enter the 10-digit National Provider Identifier of the prescriber.

**Element 11 — Address — Prescriber**

Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

**Element 12 — Telephone Number — Prescriber**

Enter the telephone number, including area code, of the prescriber.

**SECTION III — CLINICAL INFORMATION**

Providers are required to complete the appropriate sections before signing and dating the Prior Authorization Drug Attachment for Modafinil and Nuvigil® form. Providers are required to complete Section III and either Section IIIA, IIIB, IIIC, or IIID.

**Element 13 — Diagnosis Code and Description**

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

**Element 14**

Check the appropriate box to indicate whether or not the member is at least 16 years old.

**Element 15**

Check the appropriate box to indicate whether or not the member is currently taking any other stimulants.

**Element 16**

For requests for Nuvigil®, 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 to modafinil. 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. (If the request is for modafinil, check "N/A.")

**SECTION IIIA — CLINICAL INFORMATION FOR NARCOLEPSY**

**Element 17**

Check the appropriate box to indicate whether or not the member has a diagnosis of narcolepsy.

**Element 18**

Check the appropriate box to indicate whether or not the member has completed a polysomnogram (PSG). If yes, the results from a PSG **must** be submitted with this PA request for consideration.

**Element 19**

Check the appropriate box to indicate whether or not the member has taken a multiple sleep latency test (MSLT). If yes, the results from an MSLT **must** be submitted with this PA request for consideration.

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

**Element 20**

Check the appropriate box to indicate whether or not the member has a diagnosis of obstructive sleep apnea/hypopnea syndrome.

**Element 21**

Check the appropriate box to indicate whether or not the member has completed a PSG. If yes, the results from a PSG **must** be submitted with this PA request for consideration.

**Element 22**

Indicate the member's Apnea-Hypopnea Index in events per hour.

**Element 23**

Check the appropriate box to indicate whether or not the member has tried continuous positive airway pressure.

### SECTION IIIC — CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

**Element 24**

Check the appropriate box to indicate whether or not the member has a diagnosis of shift work sleep disorder.

**Element 25**

Check the appropriate box to indicate whether or not the member is a night-shift worker.

**Element 26**

Check the appropriate box to indicate whether or not the member is taking any hypnotics, sleep aids, or other medications that can cause sleepiness.

**Element 27**

Enter the member's current employer, along with his or her weekly work schedule.

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

**Element 28**

Check the appropriate box to indicate whether or not the member has a diagnosis of attention deficit disorder or attention deficit hyperactivity disorder.

**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, 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.

**Element 30**

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

**Element 31**

Check the appropriate box to indicate whether or not the member has a medical history of substance abuse or misuse. If yes, explain in the space provided.

**Element 32**

Check the appropriate box to indicate whether or not the member poses a risk of drug diversion. If yes, explain in the space provided.

### 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 — ADDITIONAL INFORMATION

**Element 35**

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