

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 programs 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. 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

Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Modafinil and Nuvigil®, F-00079. Pharmacy providers are required to use the Prior Authorization Drug Attachment for Modafinil and Nuvigil® form to request PA for Modafinil and Nuvigil® 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 drug attachment form in one of the following ways:

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

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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 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 – 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 – Prescriber

Enter the prescribing provider's National Provider Identifier 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 – Telephone 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 Prior Authorization Drug Attachment for Modafinil and Nuvigil® 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.

Element 14

Check the appropriate box to indicate whether or not the member is 16 years of age or older.

Element 15

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

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

Element 16

Check the appropriate box to indicate whether or not the member has narcolepsy with cataplexy. If yes, indicate the cataplexy symptoms experienced by the member and how frequently they occur.

Element 17

Check the appropriate box to indicate whether or not the member has narcolepsy without cataplexy.

Element 18

Check the appropriate box to indicate whether or not the member has had an overnight polysomnogram (PSG) sleep study followed by a multiple sleep latency test (MSLT).

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.

Element 19

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

Element 20

Check the appropriate box to indicate whether or not the member is taking central nervous system (CNS) depressants (i.e., 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 B – CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME (OSAHS)

Element 21

Check the appropriate box to indicate whether or not the member has OSAHS.

Element 22

Check the appropriate box to indicate whether or not the member has had an overnight PSG sleep study. Test results and provider interpretation from a PSG **must** be submitted with this PA request for consideration.

Element 23

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

Element 24

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

SECTION III C – CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER

Element 25

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

Element 26

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

Element 27

Indicate the member's current employer and his or her weekly work schedule.

Element 28

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

Element 29

Check the appropriate box to indicate whether or not the member is taking CNS depressants (i.e., 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 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.)

Element 30

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

Element 31

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 details about the unsatisfactory therapeutic responses or clinically significant adverse drug reactions, and the approximate dates each preferred stimulant was taken in the spaces provided.

Element 32

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 33

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

Element 34

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

SECTION IV – AUTHORIZED SIGNATURE

Element 34 – Signature – Prescriber

The prescriber is required to complete and sign this form.

Element 35 – Date Signed

Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V – ADDITIONAL INFORMATION

Element 36

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