

**FORWARDHEALTH  
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MODAFINIL  
AND NUVIGIL® INSTRUCTIONS**

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

ForwardHealth members 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® using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or 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 STAT-PA requests, pharmacy providers should call 800-947-1197.
- 2) For requests submitted on the ForwardHealth Portal, pharmacy providers may access [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).
- 3) 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.
- 4) 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 ID card and the EVS do not match, use the spelling from the EVS.

**Element 2 – Member ID 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 (NPI) – Prescriber**

Enter the prescribing provider's NPI 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.

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

**Element 15**

Check the appropriate box to indicate whether or not the member has OSAHS. If yes, complete the remainder of Section III A. If no, proceed to Section III B, Element 19.

**Element 16**

Check the appropriate box to indicate whether or not the member has had an overnight polysomnogram (PSG) sleep study. If yes, indicate the member's Apnea-Hypopnea Index (AHI).

**Element 17**

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

**Element 18**

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

**If requested by ForwardHealth, the provider must submit the test results and provider interpretation for the PSG.**

**SECTION III B – CLINICAL INFORMATION FOR NARCOLEPSY**

**Element 19**

Check the appropriate box to indicate whether or not the member has narcolepsy. If yes, complete the remainder of Section III B. If no, proceed to Section III C, Element 23.

**Element 20**

Check the appropriate box to indicate whether or not the member has had an overnight PSG sleep study followed by a multiple sleep latency test (MSLT) that confirm the member has narcolepsy. If yes, respond to the following questions on the form regarding PSG and MSLT sleep studies.

**PSG**

- A) Was the member's total sleep time less than 360 minutes?
- B) Did the member experience minimal sleep interruptions (e.g., respiratory events, periodic leg movements)?
- C) Did the provider interpretation indicate the member had an adequate night's sleep?

**MSLT**

- D) Was the MSLT conducted the morning after the PSG?
- E) Was the average sleep latency for all naps greater than eight minutes?
- F) Indicate the number of sleep onset rapid eye movement periods (SOREMPs) the member achieved during the MSLT (0 = no SOREMPs, 1 = one SOREMP, 2 = two or more SOREMPs).

**If requested by ForwardHealth, the provider must submit the 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.**

**Element 21**

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

**Element 22**

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 C – CLINICAL INFORMATION FOR SHIFT WORK SLEEP DISORDER**

**Element 23**

Check the appropriate box to indicate whether or not the member has shift work sleep disorder. If yes, complete the remainder of Section III C. If no, proceed to Section III D, Element 28.

**Element 24**

Check the appropriate box to indicate whether or not the member is a night-shift worker. If yes, indicate the member's employer and weekly work schedule.

**Element 25**

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

**Element 26**

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

**Element 27**

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

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

**Element 28**

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

**Element 29**

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

**Element 30**

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.

**Element 31**

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

**Element 32**

Check the appropriate box to indicate whether or not the member has a medical history of substance abuse disorder.

**Element 33**

Check the appropriate box to indicate whether or not the member poses a serious risk of drug diversion.

**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 – FOR PHARMACY PROVIDERS USING STAT-PA**

**Element 36 – National Drug Code**

Enter the appropriate 11-digit National Drug Code for each drug.

**Element 37 – Days' Supply Requested**

Enter the requested days' supply, up to 365 days.

**Element 38 – NPI**

Enter the NPI. Also enter the taxonomy code if the pharmacy provider's taxonomy code is not 333600000X.

**Element 39 – Date of Service**

Enter the requested first date of service (DOS) for the drug in MM/DD/CCYY format. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

**Element 40 – Place of Service**

Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Code	Description
01	Pharmacy
13	Assisted living facility
14	Group home
32	Nursing facility
34	Hospice
50	Federally qualified health center
65	End-stage renal disease treatment facility
72	Rural health clinic

**Element 41 – Assigned PA Number**

Enter the PA number assigned by the STAT-PA system.

**Element 42 – Grant Date**

Enter the date the PA request was approved by the STAT-PA system.

**Element 43 – Expiration Date**

Enter the date the PA expires as assigned by the STAT-PA system.

**Element 44 – Number of Days Approved**

Enter the number of days for which the PA request was approved by the STAT-PA system.

**SECTION VI – 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.