**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-02537 (11/2019)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR NON-PREFERRED
STIMULANTS, RELATED AGENTS - WAKE PROMOTING**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, refer to the Prior Authorization Drug Attachment for Non-Preferred Stimulants, Related Agents - Wake Promoting Instructions, F‑02537A. Providers may refer to the Forms page of the ForwardHealth Portal at [https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/‌ForwardHealthCommunications.aspx?panel=Forms](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms) for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Non-Preferred Stimulants, Related Agents - Wake Promoting form signed by the prescriber before submitting a prior authorization 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 ID 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. Phone Number – Prescriber      |
| **SECTION III – CLINICAL INFORMATION (Required for all requests)** |
| 13. Diagnosis Code and Description      |
| 14. Is the member 18 years of age or older? [ ]  Yes [ ]  No |
| 15. Is the member taking any drugs in the stimulants, related agents - wake promoting class? [ ]  Yes [ ]  NoIf yes, list the drug name(s) and the dosage.      |

|  |
| --- |
| 16. Has the member tried armodafinil and either experienced an unsatisfactory therapeutic response after the medication had been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction? [ ]  Yes [ ]  NoIf yes, list the dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates armodafinil was taken.      |
| 17. Does the member have a medical condition(s) preventing the use of armodafinil? [ ]  Yes [ ]  NoIf yes, list the medical condition(s) that prevents the use of armodafinil.      |
| 18. Is there a clinically significant drug interaction between another medication the member is taking and armodafinil? [ ]  Yes [ ]  NoIf yes, list the medication(s) and interaction(s).      |
| 19. Has the member tried modafinil and either experienced an unsatisfactory therapeutic response after the medication had been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction? [ ]  Yes [ ]  NoIf yes, list the dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates modafinil was taken.      |
| 20. Does the member have a medical condition(s) preventing the use of modafinil? [ ]  Yes [ ]  NoIf yes, list the medical condition(s) that prevents the use of modafinil.      |
| 21. Is there a clinically significant drug interaction between another medication the member is taking and modafinil? [ ]  Yes [ ]  NoIf yes, list the medication(s) and interaction(s).      |

|  |
| --- |
| **SECTION III A – CLINICAL INFORMATION FOR NARCOLEPSY ONLY** |
| 22. Does the member have excessive daytime sleepiness associated with narcolepsy? [ ]  Yes [ ]  No |
| 23. Has the member had an overnight polysomnogram (PSG) sleep study followed bya multiple sleep latency test (MSLT) that confirms the member has narcolepsy? [ ]  Yes [ ]  NoIf yes, provide responses to the following questions regarding the PSG and MSLT sleep studies: **PSG**A. Was the member’s total sleep time less than 360 minutes? [ ]  Yes [ ]  NoB. Did the member experience significant sleep interruptions (for example, respiratory events or periodic leg movements)? [ ]  Yes [ ]  NoC. Did the provider interpretation indicate the member had an adequate night’s sleep? [ ]  Yes [ ]  No**MSLT**D. Was the MSLT conducted the morning after the overnight PSG? [ ]  Yes [ ]  NoE. Was the average sleep latency for all naps greater than eight minutes? [ ]  Yes [ ]  NoF. Indicate the number of sleep onset rapid eye movement periods (SOREMPs)the member achieved during the MSLT.       SOREMPs0 = No SOREMPs 1 = One SOREMP 2 = Two or more SOREMPs |
| **Note: The provider is required to 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.**  |
| 24. Is the member taking any sedative hypnotics? [ ]  Yes [ ]  No |
| 25. Is the member taking central nervous system depressants (for example, anxiolytics, barbiturates, or opioids)? [ ]  Yes [ ]  NoIf yes, indicate the central nervous system depressants and daily doses. |
|  | 1.       |
|  | 2.       |
|  | 3.       |
| Are any of the above listed central nervous system depressants contributing to the member’s daytime sleepiness? [ ]  Yes [ ]  NoIf no, indicate how the prescriber evaluated the central nervous system depressants and determined they are not contributing to the member’s daytime sleepiness.       |
| **SECTION III B – CLINICAL INFORMATION FOR OBSTRUCTIVE SLEEP APNEA ONLY** |
| 26. Is the member taking any stimulants? [ ]  Yes [ ]  No |
| 27. Does the member have excessive daytime sleepiness associated with  obstructive sleep apnea? [ ]  Yes [ ]  No |
| 28. Has the member had an overnight PSG sleep study with an Apnea-Hypopnea Index greater than or equal to five events per hour? [ ]  Yes [ ]  NoIf yes, provide the date the PSG was performed and the resulting Apnea-Hypopnea Index:PSG Date:       Apnea-Hypopnea Index:       events per hour |
| **If requested by ForwardHealth, the provider is required to submit the test results and provider interpretation for the PSG.** |
| 29. Is the member currently using continuous positive airway pressure (CPAP)? [ ]  Yes [ ]  NoIf yes, will the member continue to use CPAP in combination with the requested non-preferred stimulants, related agents - wake promoting drug? [ ]  Yes [ ]  No |
| **SECTION IV – AUTHORIZED SIGNATURE** |
| 30. **SIGNATURE** –Prescriber | 31. Date Signed |
| **SECTION V – ADDITIONAL INFORMATION** |
| 32. 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.      |