**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.

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| **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  No  If yes, list the drug name(s) and the dosage. | | |

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| 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  No  If 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  No  If 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  No  If 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  No  If 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  No  If 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  No  If yes, list the medication(s) and interaction(s). |

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| **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 by a multiple sleep latency test (MSLT) that confirms the member has narcolepsy?  Yes  No  If 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  No  B. Did the member experience significant sleep interruptions (for example,  respiratory events or periodic leg movements)?  Yes  No  C. 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  No  E. Was the average sleep latency for all naps greater than eight minutes?  Yes  No  F. Indicate the number of sleep onset rapid eye movement periods (SOREMPs) the member achieved during the MSLT.       SOREMPs  0 = 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  No  If 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  No  If 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  No  If 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  No  If 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. | | |