DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02537 (11/2019)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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 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 ❑ No

If 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 ❑ 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).

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.

Reset Form