



2018 modafinil (generic Provigil®) Prior Authorization Request

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(You must complete both pages.)

Fax completed form to: 1-800-408-2386

For urgent requests, please call: 1-800-414-2386

| Patient information | | Prescriber information | |
|---|-----------------------|-------------------------------------|---------------------|
| Patient name | | Today's date | Physician specialty |
| Patient insurance ID number | | Physician name | NPI/DEA number |
| Patient address, city, state, ZIP | | Physician address, city, state, ZIP | |
| Patient home telephone number | | M.D. office telephone number | |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Patient date of birth | M.D. office fax number | |
| Diagnosis and medical information | | | |
| Medication requested <input type="checkbox"/> modafinil: <input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 200 mg tablet | | Frequency | |
| New prescription OR date therapy initiated | | Quantity | Day supply |
| Expected length of therapy | | | |
| Diagnosis (<i>Please check all boxes that apply and include all office notes supporting diagnosis.</i>) <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Obstructive sleep apnea (OSA) <input type="checkbox"/> Shift work sleep disorder (SWSD) <input type="checkbox"/> Other diagnosis/(ICD 10): _____ | | | |
| Please check all boxes that apply: | | | |
| 1. <input type="checkbox"/> All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee. | | | |
| 2. <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescriber board certified as a sleep specialist, ear, nose and throat specialist, neurologist or pulmonologist OR a consult was obtained from a board certified sleep specialist? | | | |
| 3. <input type="checkbox"/> Yes <input type="checkbox"/> No For the treatment of a confirmed diagnosis of shift work sleep disorder (SWSD): Does the patient have a job that requires them to frequently rotate shifts or work at night and be unable to adjust to their schedule? | | | |
| 4. <input type="checkbox"/> Yes <input type="checkbox"/> No For treatment of excessive daytime sleepiness associated with obstructive sleep apnea (OSA). Does patient have ALL of the following? If NO, complete section below. <input type="checkbox"/> A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSA and meets ICSD or DSM diagnostic criteria. <input type="checkbox"/> Daytime fatigue is significantly impacting, impairing, or compromising the patient's ability to function normally. | | | |

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Please check all boxes that apply (continued):

5. Yes No Does the patient have a diagnosis of narcolepsy documented by MSLT less than 10 min or other appropriate testing?

6. **Please complete this section only if your patient does not meet the standard requirements listed in question 2,3,4 and 5:**
 Please explain why your patient should be considered for an exception although they don't meet the plan's suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement. (Please note any information that is incomplete or illegible will delay the review process.)

7. Yes No **The following quantity limits (QL) apply to modafinil: 100mg (QL 30 tablets per 30 days), 200mg (QL 60 tablets per 30 days). Does the patient require higher dosage (quantity limit exception)?**
 ► If yes, indicate quantity requested: _____ per 30 days OR quantity _____ per day

The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.

The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

8. **Please list all medications the patient has tried specific to the diagnosis and specify below.**

| CURRENT/PAST MEDICATIONS USED | DATES OF TREATMENT | THERAPEUTIC OUTCOME |
|-------------------------------|--------------------|---------------------|
| | | |
| | | |
| | | |
| | | |

9. **Other supporting information**
 *NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

| | |
|-----------------------------|-------------|
| Prescriber signature | Date |
| | |