Prior Authorization Request Form for Modafinil, Armodafinil, Sunosi, Wakix

FAX this completed form to (844) 205-3386
OR Mail requests to: PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Stimulant and Related agent? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*

☐ Yes
☐ No

Medication Taken Previously (start and end date and dose):_____
_____
_____
_____

- ☐ Member has a current history (within past 90 days) of using the prescribed the requested non-preferred Stimulant and Related agent, since:_____
- ☐ Member is not receiving concurrent treatment with a sedative hypnotic
- ☐ If requesting for daily quantity exceeding daily limit (Refer to _____ https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information:_____

Therapeutic Duplication:
If concurrently prescribed a therapeutic duplicate (i.e. stimulant different from the agent being requested):

- ☐ Member is transitioned from one stimulant and related agent to another with the intent of discontinuing one of the medications
- ☐ Member has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines. Supporting evidence:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

NARCOLEPSY AND SHIFT WORK SLEEP DISORDER:

- ☐ Member has a diagnosis of narcolepsy or shift work sleep disorder confirmed according to the most recent consensus treatment guidelines (e.g. American Academy of Sleep Medicine International Classification of Sleep Disorders)

OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME (OSAHS):

- ☐ Member has a diagnosis OSAHS confirmed according to the most recent consensus treatment guidelines (e.g. American Academy of Sleep Medicine International Classification of Sleep Disorders)
- ☐ Member has a therapeutic failure of continuous positive airway pressure (CPAP) to resolve excessive daytime sleepiness despite compliance to CPAP treatment documented by one of the following:
  - ☐ Epworth Sleepiness Scale >10: _____
  - ☐ Multiple Sleep Latency Test (MSLT) < 8 minutes: _____
- ☐ Member cannot use CPAP for a medical reason, rational:_____
- ☐ Member tried and failed an oral appliance for OSAHS to resolve daytime sleepiness

MULTIPLE SCLEROSIS-RELATED FATIGUE:

- ☐ Member is receiving treatment for multiple sclerosis
- ☐ Member is not being treated, medical records document the rational for the member not being treated

RENEWAL REQUESTS:

- ☐ Member has documentation of tolerability and experienced a positive clinical response to requested medication evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

PA Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)