

Armodafinil, Modafinil - Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Apple Health Preferred Drug list: <https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx>

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

1. Is this request for a continuation of existing therapy? Yes No
 If yes, does patient have documentation of positive clinical response? Yes No

2. Please indicate patient's diagnosis:
 - Narcolepsy with excessive somnolence, confirmed with a sleep study and multiple sleep latency test (MSLT).
 - Obstructive Sleep Apnea with residual excessive somnolence, confirmed with a sleep study.
 - Shift work sleep disorder
 - Other. Specify: _____

3. For armodafinil, has patient tried and failed modafinil for a minimum of 60 days? Yes No

4. For patients 17 years of age or younger: Has an agency-designated mental health specialist from the Second Opinion Network (SON) performed a required second opinion review? Yes No

For diagnosis of obstructive sleep apnea, please answer the following:

5. Has patient achieved normalized breathing and oxygenation with any of the following therapies (check all that apply)?
 - Continuous positive airway pressure (CPAP)
 - Bilevel positive airway pressure (BIPAP)
 - Other. Specify: _____

6. Does patient have documentation within the past 6 months, demonstrating adherence to any of the following (check all that apply)?
 - CPAP or BIPAP therapy (CPAP or BIPAP is used for 70% of nights for a minimum of 4 hours per night)
 - Mandibular advancement device
 - Other. Specify: _____

7. Does the patient have documentation within the last 6 months demonstrating they are adherent to mandibular advancement device? Yes No

For diagnosis of shift work sleep disorder or sleep deprivation, please answer the following:

8. Does patient have clinical documentation that demonstrates concomitant use of nonpharmacologic interventions (i.e. counseling, sleep hygiene)? Yes No

For continuation of therapy, documentation of positive clinical response and chart notes are required.

For diagnosis of narcolepsy, provide the following:

- sleep study and multiple sleep latency test (MSLT)
- chart notes

For diagnosis of obstructive sleep apnea, provide the following:

- sleep study
- documentation of CPAP compliance (compliance report of usage) in the last 6 months
- chart notes

For diagnosis of shift work sleep disorder or sleep deprivation, provide the following:

- chart notes

Prescriber signature	Prescriber specialty	Date
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