



# 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

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 DOCUMENTATION (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: _____	
<b>Requests for all non-preferred medications:</b> Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Stimulant and Related agent? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes	<b>Medication Taken Previously</b> (start and end date and dose): _____ _____ _____
		<input type="checkbox"/> No	_____ _____
<input type="checkbox"/> Member has a current history (within past 90 days) of using the prescribed the requested non-preferred Stimulant and Related agent, since: _____			
<input type="checkbox"/> Member is not receiving concurrent treatment with a sedative hypnotic			
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to <a href="https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx">https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx</a> ), please provide supporting information: _____			
<b>Therapeutic Duplication:</b>			
If concurrently prescribed a therapeutic duplicate (i.e. stimulant different from the agent being requested):			
<input type="checkbox"/> Member is transitioned from one stimulant and related agent to another with the intent of discontinuing one of the medications			
<input type="checkbox"/> 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:			
<input type="checkbox"/> 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):			
<input type="checkbox"/> 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)			
<input type="checkbox"/> 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:			
<input type="checkbox"/> Epworth Sleepiness Scale >10: _____			
<input type="checkbox"/> Multiple Sleep Latency Test (MSLT) < 8minutes: _____			
<input type="checkbox"/> Member cannot use CPAP for a medical reason, rational: _____			
<input type="checkbox"/> 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 rationale 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 :**

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