envolve Pharmacy Solutions

pa health & wellness

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

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions 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 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: ______________________	
Did the prescriber or prescriber's delegate search the PDMP to review the member's controlled substance prescription history before issuing this prescription for the requested agent?	☐ Yes ☐ No	*Submit documentation.*
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	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

- ☐ Member has a current history (within past 90 days) of using the prescribed the requested non-preferred anticonvulsant, since:______________________
- ☐ Member was assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by prescribing provider
- ☐ Member has been educated on the potential adverse effects of stimulants, including the risk for misuse, abuse, and addiction
- ☐ For member's with a history of comorbid substance dependency, abuse, or diversion has results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including oxycodone, fentanyl and tramadol)
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), 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

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:

Envolve Pharmacy Solutions 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.)