

# Pharmacy

## PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

# Provigil<sup>®</sup> (modafinil [generics])

**URGENT** (life threatening)

**Non-Urgent** (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

### Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

### Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

Is this provider a  neurologist,  pulmonologist, or  sleep specialist?

### PRODUCT INFORMATION

Provigil 100 mg tablets

Provigil 200 mg tablets

**Dose:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

### PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Provigil<sup>®</sup> (modafinil) requires the following information to certify:

#### Patient must have met the following requirements for one of the following diagnoses:

- Patient has a diagnosis of **narcolepsy**, confirmed by polysomnography, with a documented therapeutic trial with one of the following stimulants: amphetamine salts, dextroamphetamine, or methylphenidate.
- Patient has a diagnosis of **obstructive sleep apnea/hypopnea syndrome (OSAHS)**, confirmed by polysomnography with respiratory monitoring, and is using CPAP for a minimum of 2 months for at least 4 hours per night.
- Patient has a diagnosis of **shift work sleep disorder (SWSD)**
- Patient has a diagnosis of **multiple sclerosis related fatigue** (this indication is not covered for Medicare members)
- Patient has a diagnosis of **cancer related fatigue** (this indication is not covered for Medicare members), with a documented therapeutic trial with one of the following stimulants: amphetamine salts, dextroamphetamine, methylphenidate, or Daytrana
- The daily dosage does not exceed 400 mg

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**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION**

Authorization for Provigil<sup>®</sup> (modafinil) requires the following information to certify:

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**A. What is the patient's diagnosis?**

- a.  **narcolepsy**
- i. Has the diagnosis of narcolepsy been confirmed by polysomnography?  
 Yes  
 No – *Rationale for use:* \_\_\_\_\_
- ii. Which of the following medications has the patient had a therapeutic trial with?  
 amphetamine salts  
 dextroamphetamine (e.g. Dexedrine)  
 methylphenidate (e.g. Concerta, Metadate CD, Methylin, Ritalin)  
 Other: \_\_\_\_\_  
 None of the above – *Rationale for use:* \_\_\_\_\_
- b.  **obstructive sleep apnea/hypopnea syndrome (OSAHS)**
- i. Has the diagnosis of obstructive sleep apnea been confirmed by polysomnography with respiratory monitoring?  
 Yes  
 No – *Rationale for use:* \_\_\_\_\_
- ii. Has the patient been utilizing CPAP therapy for at least 2 months?  
 Yes  
 No – *Rationale for use:* \_\_\_\_\_
- iii. Is the patient using CPAP for at least 4 hours per night?  
 Yes  
 No – *Rationale for use:* \_\_\_\_\_
- c.  **shift work sleep disorder (SWSD)**
- d.  **multiple sclerosis related fatigue** (not covered for Medicare members)
- e.  **cancer related fatigue** (not covered for Medicare members)
- i. Which of the following medications has the patient had a therapeutic trial with?  
 amphetamine salt combo (e.g. Adderall, Adderall XR)  
 dextroamphetamine (e.g. Dexedrine)  
 methylphenidate (e.g. Concerta, Metadate CD, Methylin, Ritalin)  
 Daytrana  
 Other: \_\_\_\_\_  
 None of the above – *Rationale for use:* \_\_\_\_\_
- f.  *Other:* \_\_\_\_\_  
*Rationale for use:* \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

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**FOR MEDICARE ONLY**

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If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1.  All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2.  The number of doses available under a dose restriction for the prescription drug:
  - a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on 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.
3.  The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
  - a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on 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.
  - c.  Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4.  None of the above apply

**\*\*If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

**\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\***

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**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**