HIGHMARK | HIGHMARK

Medication Prior Authorization Form
Fax to 1-866-240-8123

Provigil (Modafinil)

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

Requested Drug		Requested Quantity	Requested Day Supply
☐ Brand Provigil	☐ Generic Modafinil		☐ 30 days ☐ 90 days ☐ Other: _____
Requested Strength			
☐ 100mg	☐ 200mg		
Directions			
Diagnosis and/or ICD-10 code(s)			

Medication History:

1. Has the member experienced therapeutic failure, contraindication, or intolerance to a generic CNS stimulant (for example, dextroamphetamine, methylphenidate)?	Yes	No

2. Please provide any other medications that the member has tried and failed:

_____

_____

_____

OBSTRUCTIVE SLEEP APNEA

If the requested medication is being used to treat **obstructive sleep apnea**, please answer the following:

1. Is the member currently receiving and compliant with positive airway pressure (PAP)?	Yes	No
2. Has the member experienced therapeutic failure, intolerance, or contraindication to positive airway pressure (PAP)?	Yes	No
3. Is the member currently using and compliant with a custom, titratable oral appliance?	Yes	No

4. Please provide the following from the member's **diagnostic** polysomnography, recording time, or home sleep apnea test:

Apnea/hypopnea index (AHI): _____ events per hour

Respiratory Disturbance index (RDI): _____ events per hour

Respiratory Event index (REI): _____ events per hour

5. Is the member experiencing any of the following symptoms? Please select **ALL** that apply:

☐ Coronary artery disease ☐ Unrefreshing sleep ☐ Mood disorder ☐ Insomnia
☐ Congestive heart failure ☐ Cognitive dysfunction ☐ Atrial fibrillation ☐ Fatigue
☐ Type 2 diabetes mellitus ☐ Daytime sleepiness ☐ Hypertension ☐ Stroke
☐ Unintentional sleep episodes during wakefulness ☐ Waking up holding breath, gasping, or choking
☐ Bed partner describes loud snoring, breathing interruptions or both

NARCOLEPSY

If the requested medication is being used to treat **narcolepsy**, please answer the following:

1. Please provide baseline data of the following:

   Epworth Sleepiness Scale (ESS): _____

   Maintenance of Wakefulness Test (MWT): _____

2. Please provide the following results of the member's multiple sleep latency test (MSLT):

   Mean sleep latency (in minutes): _____

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____

3. Please provide the following from the member's diagnostic polysomnography:

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____

4. If the member has hypocretin-1 deficiency, please provide the following:

   Cerebrospinal fluid hypocretin-1 level (in pg/mL): _____

   Cerebrospinal fluid hypocretin-1 laboratory reference range: _____

MULTIPLE SCLEROSIS

If the member has **multiple sclerosis**, please answer the following:

1. Is the member experiencing significant fatigue?	Yes	No

SHIFT-WORK SLEEP DISORDER

If the requested medication is being used to treat **shift-work sleep disorder**, please answer the following:

1. Does the member have excessive sleepiness or insomnia that is temporarily associated with a recurring work schedule that overlaps the usual time for sleep?	Yes	No
2. Are the member's symptoms accompanied by a reduction of total sleep time?	Yes	No
3. Has the member experienced symptoms for at least 3 months?	Yes	No
4. Does the member have sleep log or actigraphy monitoring for at least 14 days including both work and free days?	Yes	No
5. Is the member's sleep disturbance due to another current sleep disorder, medical or neurological disorder, mental disorder, medication use, or substance use disorder?	Yes	No

IDIOPATHIC HYPERSOMNIA

If the requested medication is being used to treat **idiopathic hypersomnia**, please answer the following:

1. Please provide baseline data of the following:

   Epworth Sleepiness Scale (ESS): _____

   Maintenance of Wakefulness Test (MWT): _____

2. Please provide the following results of the member's multiple sleep latency test (MSLT):

   Mean sleep latency (in minutes): _____

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____

3. Please provide the following from the member's diagnostic polysomnography:

   Number of sleep-onset rapid eye movement periods (SOREMPs): _____

4. Does the member have a diagnosis of cataplexy?	Yes	No
5. Does the member have a polysomnography demonstrating total 24-hour sleep time greater than or equal to 660 minutes (11 hours)?	Yes	No
6. Does the member have wrist actigraphy demonstrating greater than or equal to 660 minutes (11 hours) of sleep per 24 hours averaged across greater than or equal to 7 days of monitoring?	Yes	No

Reauthorization:

1. Is the member currently on therapy with the requested medication?	Yes	No
If **YES**, please answer the following questions:		
1a. While on therapy with the requested medication, have the member's symptoms (for example, fatigue) improved?	Yes	No
1b. While on therapy with the requested medication, has the member experienced improvement in daytime sleepiness?	Yes	No
1c. While on therapy with the requested medication, has the member experienced a decrease in daytime sleepiness as proven by improvement on the Epworth Sleepiness Scale or Maintenance of Wakefulness Test compared to baseline?	Yes	No

Quantity:

1. Does the member need more than 1 tablet per day of Provigil (Modafinil) 200mg?	Yes	No
If **YES**, please answer the following questions:		
1a. Has the member's daytime sleepiness been inadequately controlled on Provigil (Modafinil) 200mg daily?	Yes	No
1b. Has the member's daytime sleepiness been inadequately controlled on Provigil (Modafinil) 200mg once daily in the morning?	Yes	No

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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