COVENTRY® Health Care
An Aetna Company

First Health® Part D
from Coventry Health Care
An Aetna Company

2016 Modafinil (generic Provigil®) prior authorization request

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(You must complete both pages.)

Please fax completed form to: 1-800-639-9158 **For urgent requests, please call: 1-800-551-2694**

Patient information		**Prescriber information**	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		M.D. office telephone number	
Gender ☐ Male ☐ Female	Patient date of birth	M.D. office fax number	

Diagnosis and medical information

Medication requested ☐ Modafinil: ☐ 100 mg tablet ☐ 200 mg tablet		**Frequency**	
New prescription OR date therapy initiated	**Quantity**	**Day supply**	**Expected length of therapy**

Diagnosis ***(Please check all boxes that apply and include all office notes supporting diagnosis.)***

☐ Narcolepsy ☐ Obstructive sleep apnea/hypopnea syndrome (OSAHS) ☐ Shift work sleep disorder (SWSD)

☐ Other diagnosis: _____

Please check all boxes that apply:

1. ☐ **All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.**

2. ☐ Yes ☐ No **Is the prescriber board certified as a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a board certified sleep specialist? If NO, complete section below:**

Please complete this section below only if your patient does not meet the standard requirements listed above.

Please explain why your patient should be considered for exception although not meeting the plan's suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement. (Please note any information that is incomplete or illegible will delay the review process.)

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3. ☐ Yes ☐ No **For the treatment of a confirmed diagnosis of shift work sleep disorder (SWSD).** Does the patient have a job that requires them to frequently rotate shifts or work at night and be unable to adjust to their schedule?

4. ☐ Yes ☐ No **For treatment of excessive daytime sleepiness associated with obstructive sleep apnea (OSA). Does patient have ALL of the following? If NO, complete section below:**

- ☐ A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSA and meets ICSD or DSM diagnostic criteria.
- ☐ Daytime fatigue is significantly impacting, impairing, or compromising the patient's ability to function normally.
- ☐ Prescribing physician has established a patient care plan to treat the cause of OSA in conjunction with treating the daily fatigue.

Please complete this section below only if your patient does not meet the standard requirements listed above.

Please explain why your patient should be considered for exception although not meeting the plan's suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement. (Please note any information that is incomplete or illegible will delay the review process.)

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5. ☐ Yes ☐ No **The following quantity limits (QL) apply to modafinil: 100mg QL 30 units per 30 days, 200mg QL 60 units per 30 days (State of Illinois QL 30 units per 30 days). Does the patient require higher dosage (quantity limit exception)?**

►If yes, indicate quantity requested: _____ per 30 days OR quantity _____ per day

- ☐ The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.
- ☐ The number of doses available under the dose restriction for the prescription drug, based on both 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.

6. ☐ **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

7. ☐ **Other supporting information**

*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

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I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	**Date**