Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

MODAFINIL AGENTS Renewal

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	Prescriber PA PROMISe ID:	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient previously been approved for modafinil or armodafinil?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of obstructive sleep apnea (OSA)?

☐ Yes ☐ No

Q3. Does the patient continue to use continuous positive airway pressure (CPAP) to treat the underlying OSA? (Please attach documentation of compliant use.)

☐ Yes ☐ No

Q4. Has the patient had a positive response to modafinil/armodafinil therapy with an improvement in symptoms from baseline?

☐ Yes ☐ No

Q5. Requested Duration:

☐ 12 Months

Q6. Additional Information:

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

MODAFINIL AGENTS Renewal

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

Updated 2018