Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

MODAFINIL AGENTS

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. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of excessive daytime sleepiness associated with narcolepsy?

☐ Yes ☐ No

Q3. Has the diagnosis been confirmed by a history consistent with narcolepsy, a polysomnography (PSG) , and a multiple sleep latency test (MSLT)? (Please attach documentation.)

☐ Yes ☐ No

Q4. Has the patient tried and failed at least one stimulant medication that is FDA-approved to treat narcolepsy (such as methylphenidate, amphetamine salts, or dextroamphetamine)? Please include documentation of agent(s) used, with dose, dates/duration of use, and specific outcome(s).

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea (OSA)?

☐ Yes ☐ No

Q6. Has the diagnosis been confirmed by a history consistent with obstructive sleep apnea and a polysomnogram (PSG)? (Please attach documentation.)

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

MODAFINIL AGENTS

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:**

☐ Yes	☐ No
Q7. Did the patient experience continued symptoms despite the use of continuous positive airway pressure (CPAP) that was initiated at a pressure determined by the sleep study? (Please attach documentation of compliant use.)	
☐ Yes	☐ No
Q8. Did the patient experience continued symptoms despite a retitration of CPAP to an appropriate pressure determined by sleep study and an assessment of other possible causes of CPAP treatment failure (such as mask fitting or machine function issues)? (Please attach documentation of reassessments and compliant use.)	
☐ Yes	☐ No
Q9. Will the patient continue to use CPAP to treat the underlying OSA?	
☐ Yes	☐ No
Q10. Does the patient have a diagnosis of excessive sleepiness associated with shift work disorder (SWD)?	
☐ Yes	☐ No
Q11. Has the patient experienced symptoms associated with a shift work schedule for at least 1 month?	
☐ Yes	☐ No
Q12. Have other possible causes of symptoms (such as other sleep disorders, medical disorders, medication use, etc.) been ruled out?	
☐ Yes	☐ No
Q13. Has the patient tried at least one pharmacologic or nonpharmacologic method to improve symptoms (such as sleep hygiene improvement, sleep-wake scheduling/planned naps, hypnotics, or stimulants)? Please describe method(s) tried.	
☐ Yes	☐ No
Q14. Requested Duration:	
☐ 3 Months	
Q15. Additional Information:	

Prescriber Signature _____ Date _____

Updated 2018

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document