Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Modafinil Armodafinil (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Modafinil Armodafinil (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

modafinil armodafinil

Other, Please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medicine in the past for this patient (e.g., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 8.]

2. Is the medication prescribed for fatigue related to obstructive sleep apnea? Y N

   [If no, then skip to question 4.]

3. Is the patient compliant with using a CPAP or BIPAP? Y N

   [If no, then no further questions.]

[If yes, then skip to question 6.]

4. Is the medication prescribed for fatigue related to shift-work sleep disorder? Y N

   [If no, then skip to question 6.]

5. Is the patient still working a swing-shift? Y N

   [If no, then no further questions.]

6. Did the patient have a documented clinical response to treatment? Y N

7. Is this a request for additional quantity since the last prior authorization approval? Y N

   [If yes, then skip to question 25.]

   [If no, then no further questions.]

8. Is this a request for armodafinil? Y N

   [If no, then skip to question 10.]

9. Did the patient fail a 2-month trial of modafinil? Y N

   If yes, describe reason for treatment failure:

   _____

   [If no, then no further questions.]

10. Is the requested drug being prescribed for the diagnosis of narcolepsy? Y N

    [If no, then skip to question 12.]

11. Was diagnostic testing completed to confirm a diagnosis of narcolepsy (i.e., multiple sleep latency test (MSLT) or polysomnography)? Y N

    [If yes, then skip to question 24.]

    [If no, then no further questions.]

12. Is the requested drug being prescribed for the diagnosis of Obstructive Sleep Apnea (OSA)? Y N

    [If no, then skip to question 16.]

13. Did the patient have a polysomnography that confirmed the diagnosis of OSA? Y N

[If no, then no further questions.]

14. Does the patient remain symptomatic despite compliance with CPAP or BIPAP? Y N

    [If no, then no further questions.]

15. Will the patient continue to use CPAP or BIPAP after the requested medication is started? Y N

    [If no, then no further questions.]

    [If yes, then skip to question 22.]

16. Is the requested drug being prescribed for excessive daytime sleepiness due to shift-work sleep disorder (SWD)? Y N

    [If no, then skip to question 19.]

17. Did the patient have a polysomnography that confirmed the diagnosis of SWD and ruled out other types of sleep disorders? Y N

    [If no, then no further questions.]

18. Have the patient's symptoms been present for at least 3 months? Y N

    [If no, then no further questions.]

    [If yes, then skip to question 22.]

19. Is the requested drug being prescribed for the treatment of Idiopathic hypersomnia? Y N

    [If no, then no further questions.]

20. Has the patient had a trial and failure of 2 formulary stimulants (e.g., amphetamine/dextroamphetamine, methylphenidate)? Y N

    [If no, then no further questions.]

21. Is the diagnosis supported by polysomnography, MSLT, and clinical evaluation including ALL of the following to rule out other causes of insomnia: Y N
    A) Patient has had daily periods of irrepressible need to sleep or daytime lapses into sleep for at least three months,
    B) MSLT documents less than 2 sleep-onset rapid eye movement periods (SOREMPs), or no SOREMPs if the REM sleep latency on the polysomnogram was less than or equal to 15 minutes,
    C) Patient has mean sleep latency of less than or equal to 8 minutes

on MSLT OR a total 24-hour sleep time of great than or equal to 660 minutes?

If yes, please submit documentation of above including polysomnography and MSLT

[If no, then no further questions.]

22. Is the daytime sleepiness significantly impacting, impairing, or compromising the patient's ability to function normally? Y N

[If no, then no further questions.]

23. Is the medication prescribed by, or in consultation with, a sleep specialist? Y N

[If no, then no further questions.]

24. Is the patient 17 years of age or older? Y N

25. Is the requested dose greater than FDA recommended maximum daily dosage? Y N

If yes, please submit clinical evidence of safety and efficacy from peer-reviewed journal articles.

[If yes, then no further questions.]

26. Is this request for quantity limit exception? (Refer to formulary for covered quantity.) Y N

[If no, then no further questions.]

27. Is the dosing based on inability to swallow optimal dose? Y N

[If yes, then no further questions.]

28. Is the dosing due to patient ability to not tolerate total daily dose in one administration? Y N

[If yes, then no further questions.]

29. Can the prescribed total daily dose be achieved with a lower quantity of a higher strength that does not exceed the quantity limit (e.g. one 60mg tablet/day in place of two 30 mg tablets/day)? Y N

    If no, please provide reason:

    _____

    [Note: Dose Optimization, use of a higher strength to allow a patient to take fewer doses to achieve the same total daily dose.]

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date