05/09/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Modafinil/Nuvigil (IL88)

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 Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Modafinil/Nuvigil (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Modafinil Tablets Nuvigil Tablets (armodafinil)

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is this a renewal request? Y N

   [If no, then skip to question 3.]

2. Is the patient having a response to treatment? If yes, please submit supporting clinical notes. Y N

   [No further questions.]

3. Does the patient have a diagnosis of Narcolepsy? Y N

   [If no, then skip to question 5.]

4. Has the patient had a trial and failure of, or documented contraindication to formulary CNS stimulants? Y N

   [If yes, then skip to question 8.]

   [If no, then no further questions.]

5. Does the patient have a diagnosis of Obstructive Sleep Apnea? Y N

   [If no, then skip to question 7.]

6. Has the patient had a trial and failure of, or Obstructive Sleep Apnea continues despite use of CPAP? Y N

   [If yes, then skip to question 8.]

   [If no, then no further questions.]

7. Does the patient have a diagnosis of Circadian rhythm disruption (i.e., shift-work sleep disorder)? If yes, please submit documentation to support the diagnosis (e.g., other causes of hypersomnolence have been ruled-out, Sleep study evaluation). Y N

   [If no, then skip to question 9.]

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

   [No further questions.]

9. Is this request for modafinil (Provigil)? Y N

   [If no, then no further questions.]

10. Does the patient have a diagnosis of Cancer-related fatigue? If yes, please submit documentation supporting diagnosis of severe fatigue. Y N

    [If no, then skip to question 12.]

11. Is the patient 18 years of age or older? Y N

    [If yes, then skip to question 14.]

    [If no, then no further questions.]

12. Is the patient 16 years of age or older? Y N

	Y	N
13. Does the patient have a diagnosis of Fatigue due to Multiple Sclerosis (MS)? [If no, then skip to question 15.]		
14. Has the patient had a trial and failure of methylphenidate? [No further questions.]	Y	N
15. Does the patient have a diagnosis of Idiopathic hypersomnia supported by polysomnography?	Y	N
16. Has the patient had a trial and failure of 2 formulary stimulants?	Y	N

Comments:

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

Prescriber (Or Authorized) Signature Date