Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Armodafinil - Modafinil (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 New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Armodafinil - Modafinil (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

armodafinil modafinil

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

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

   [If no, then skip to question 7.]

2. Is the requested drug being prescribed for excessive daytime sleepiness associated with obstructive sleep apnea? Y N

   [If no, then skip to question 4.]

3. Is the member compliant with using a Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BIPAP)? Y N

[If no, then no further questions.]

[If yes, then skip to question 6.]

4. Is the requested drug being prescribed for excessive daytime sleepiness associated with shift-work sleep disorder? Y N

   [If no, then skip to question 6.]

5. Is the member still a shift-worker? Y N

   [If no, then no further questions.]

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

   [No further questions.]

7. Is this a request for modafinil? Y N

   [If no, then skip to question 9.]

8. Did the member fail a trial of armodafinil? Y N

   If yes, describe reason for treatment failure:

   _____

   [If no, then no further questions.]

9. Is the requested drug being prescribed for the diagnosis of excessive daytime sleepiness associated with narcolepsy? Y N

   [If no, then skip to question 11.]

10. Was diagnostic testing completed to support a diagnosis of narcolepsy (such as multiple sleep latency test (MSLT) or polysomnography)? Y N

    [If yes, then skip to question 20.]

    [If no, then no further questions.]

11. Is the requested drug being prescribed for the diagnosis of excessive daytime sleepiness associated with Obstructive Sleep Apnea (OSA)? Y N

    [If no, then skip to question 15.]

12. Did the member have a polysomnography that confirmed the diagnosis of OSA (Obstructive Sleep Apnea)? Y N

    [If no, then no further questions.]

13. Does the member remain symptomatic despite optimization and compliance with Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BIPAP) for at least one month? Y N

    [If no, then no further questions.]

14. Will the member continue to use CPAP (Continuous Positive Airway Pressure) or BIPAP (Bilevel Positive Airway Pressure) after the requested drug is started? Y N

    [If no, then no further questions.]

    [If yes, then skip to question 18.]

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

    [If no, then no further questions.]

16. Did the member have a polysomnography that ruled out other types of sleep disorders? Y N

    [If no, then no further questions.]

17. Have the member's symptoms been present for 3 or more months? Y N

    [If no, then no further questions.]

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

    [If no, then no further questions.]

19. Is the requested drug being prescribed by, or in consultation with, a sleep specialist? Y N

    [If no, then no further questions.]

20. Is the member 17 years of age or older? 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**