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Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Armodafinil and Modafinil Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ armodafinil (Section I) ☐ modafinil

Dose and frequency of medication requested _____

Indication (Check all that apply.)

☐ Excessive daytime sleepiness associated with narcolepsy (Section II)
☐ Excessive daytime sleepiness associated with obstructive sleep apnea (Section III)
☐ Excessive daytime sleepiness associated with shift work sleep disorder (Section IV)
☐ Other (Section V) _____

Section I. Please complete for all requests for armodafinil.

Has the member tried modafinil for the treatment of this condition?

☐ Yes. Please list the dates/durations of use and outcomes below.

Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response.

_____

☐ No. Please describe why the member is not a candidate for modafinil.

_____

Section II. Please complete for requests for the diagnosis of narcolepsy.

1. Has the member had a sleep study (polysomnogram or multiple sleep latency test) that diagnosed narcolepsy?

☐ Yes. Please include a copy of the sleep study with PA submission.

☐ No. Please explain why this member has not had a sleep study or why treatment is required when sleep study did not document narcolepsy. _____

2. Has the member tried a cerebral stimulant medication for the treatment of this condition? (Include details of trials below.)
   ☐ Yes. Please list the drug name, dates of trials, and outcomes below.
   Drug _____ Dates of use _____
   ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please describe clinical rationale why cerebral stimulants are not appropriate for this member.
   _____

Section III. Please complete for requests for the diagnosis of obstructive sleep apnea.

1. Has the member had a sleep study (polysomnogram) that diagnosed obstructive sleep apnea?
   ☐ Yes. Please include medical records with submission. ☐ No
2. Was a sleep study performed to determine the appropriate pressure for CPAP/biPAP therapy or does the member use an automatically titrating CPAP/biPAP machine?
   ☐ Yes. Please include medical records with submission. ☐ No
3. Is the member experiencing residual daytime sleepiness despite compliance to a CPAP/biPAP therapy and a polysomnogram using the treatment that confirms efficacy?
   ☐ Yes. Please include medical records with submission. ☐ No
4. Has the member undergone surgical treatment for obstructive sleep apnea and is still experiencing daytime sleepiness?
   ☐ Yes. Please include medical records documenting this outcome with submission. ☐ No
5. Is the member experiencing residual daytime sleepiness after failure of CPAP/biPAP, despite compliance to an oral appliance and a polysomnogram using the appliance that confirms efficacy?
   ☐ Yes. Please include medical records documenting this outcome with submission. ☐ No

Section IV. Please complete for all requests for shift work sleep disorder.

1. Has the member tried a cerebral stimulant medication for the treatment of this condition? (Include details of trials below.)
   ☐ Yes. Please list the drug name, dates of trials, and outcomes below.
   Drug _____ Dates of use _____
   ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please describe clinical rationale why cerebral stimulants are not appropriate for this member.
   _____
2. Has the member tried a hypnotic agent for the treatment of this condition? (Include details of trials below.)
   ☐ Yes. Please list the drug name, dates of trials, and outcomes below.
   Drug _____ Dates of use _____
   ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please describe clinical rationale why a hypnotic agent is not appropriate for this member.
   _____
3. Has the member tried melatonin for the treatment of this condition? (Include details of trials below.)
   ☐ Yes. Please list the dates of trials and outcomes below.
   Drug _____ Dates of use _____
   ☐ Adverse reaction ☐ Inadequate response ☐ Other

over

Briefly describe details of adverse reaction, inadequate response, or other.

_____

☐ No. Please describe clinical rationale why melatonin is not appropriate for this member.

_____

Section V. Please complete for all requests for any diagnoses not listed above.

1. Please provide medical necessity for the use of armodafinil or modafinil in the requested diagnosis.

_____

2. Please list the drug names, dates, and outcomes of prior medication trials for the requested condition below.

Drug _____ Dates of use _____

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

Drug _____ Dates of use _____

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

Section VI. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.).

Signature required _____

Printed name of prescribing provider _____ Date _____

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