CAREFIRST - DC EXCHANGE 5T
Modafinil (HMF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Modafinil (HMF).

Patient Information

Patient Name:
Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐
Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐
Physician Addr.:
City, St, Zip:

Drug Name (select from list of drugs shown)

Modafinil 100mg Modafinil 200mg

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Does the patient have a diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)?	**Y** ☐	**N** ☐
2.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
3.	Has the patient achieved or maintained a positive response to treatment from baseline?	**Y** ☐	**N** ☐
4.	Is the patient compliant with using continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP)?	**Y** ☐	**N** ☐
5.	Is the requested drug being prescribed by, or in consultation with, a sleep specialist?	**Y** ☐	**N** ☐
6.	Is the diagnosis confirmed by polysomnography?	**Y** ☐	**N** ☐
7.	Has the patient been receiving treatment for the underlying airway obstruction (continuous positive airway pressure [CPAP] or bilevel positive airway pressure [BIPAP]) for at least one month?	**Y** ☐	**N** ☐
8.	Will the patient continue to use continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) after the requested drug is started?	**Y** ☐	**N** ☐
9.	Does the patient have a diagnosis of excessive sleepiness associated with narcolepsy?	**Y** ☐	**N** ☐
10.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
11.	Has the patient achieved or maintained a positive response to treatment from baseline?	**Y** ☐	**N** ☐
12.	Is the requested drug being prescribed by, or in consultation with, a sleep specialist?	**Y** ☐	**N** ☐
13.	Is the diagnosis confirmed by a sleep study?	**Y** ☐	**N** ☐

14.	Does the patient have a diagnosis of excessive sleepiness associated with Shift Work Disorder (SWD)?	**Y** ☐	**N** ☐
15.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
16.	Has the patient achieved or maintained a positive response to treatment from baseline?	**Y** ☐	**N** ☐
17.	Is the patient still a shift-worker?	**Y** ☐	**N** ☐
18.	Is the requested drug being prescribed by, or in consultation with, a sleep specialist?	**Y** ☐	**N** ☐
19.	Has a sleep log and actigraphy monitoring been completed for at least 14 days and shows a disrupted sleep and wake pattern?	**Y** ☐	**N** ☐
20.	Have the patient's symptoms been present for 3 or more months?	**Y** ☐	**N** ☐
21.	Is the requested drug being prescribed for idiopathic hypersomnia?	**Y** ☐	**N** ☐
22.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
23.	Has the patient achieved or maintained a positive response to treatment from baseline?	**Y** ☐	**N** ☐
24.	Is the requested drug being prescribed by, or in consultation with, a sleep specialist?	**Y** ☐	**N** ☐
25.	Has the patient experienced the presence of daytime lapses into sleep or daily irrepressible periods of need to sleep for at least 3 months?	**Y** ☐	**N** ☐
26.	Has insufficient sleep syndrome been ruled out, such as by lack of improvement of sleepiness after an adequate trial of increased nocturnal time in bed, preferably confirmed by at least a week of sleep log with wrist actigraphy?	**Y** ☐	**N** ☐
27.	Has a multiple sleep latency test (MSLT) documented fewer than two sleep onset rapid eye movement periods (SOREMPs) or no SOREMPs if the REM latency on the preceding polysomnogram was less than or equal to 15 minutes?	**Y** ☐	**N** ☐
28.	Has sleep lab evaluation shown at least ONE of the following: A) mean sleep latency on multiple sleep latency test (MLST) of less than or equal to 8 minutes, B) total 24-hour sleep time of greater than or equal to 660 minutes on 24-hour polysomnographic monitoring after correcting any chronic sleep deprivation or by wrist actigraphy in association with a sleep log and averaged over at least 7 days of unrestricted sleep?	**Y** ☐	**N** ☐
29.	Does the patient have cataplexy?	**Y** ☐	**N** ☐
30.	Are the patient's hypersomnolence or multiple sleep latency test (MSLT) results better explained by ANY of the following: A) another sleep disorder, B) other medical or psychiatric disorder, C) use of drugs or medications?	**Y** ☐	**N** ☐
31.	Is the requested drug being prescribed for multiple sclerosis-related fatigue?	**Y** ☐	**N** ☐
32.	Is the request for continuation of therapy?	**Y** ☐	**N** ☐
33.	Has the patient achieved or maintained a positive response to treatment from baseline?	**Y** ☐	**N** ☐
34.	Does the patient require MORE than the plan allowance of 60 tablets per month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date