Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

MODAFINIL
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

□ Narcolepsy	Please provide chart documentation of a sleep study and previous trial/failure of stimulants (such as methylphenidate, amphetamine/dextroamphetamine, dextroamphetamine).	
□ Obstructive sleep apnea/hypopnea syndrome	Please provide chart documentation of a sleep study and compliance with use of a CPAP machine.	
□ Shift work sleep disorder	Are there any other medical or mental disorders that account for the symptoms? If yes, please list:_____ Please indicate number of over-night shifts worked per month:_____ □ Please provide chart documentation of the shift work schedule. □ Please provide chart documentation of a sleep study.	□ Yes □ No
□ Chronic fatigue due to Multiple Sclerosis	Has member previous had a trial/failure of amantadine?	□ Yes □ No
□ Other	Diagnosis:_____	Date Diagnosed:_____

Please provide any additional information which should be considered in the space below: