Health Partners Medicare

***PRIOR AUTHORIZATION REQUEST FORM***

Modafinil - Medicare

**Phone: 215-991-4300** **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Medicare | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
**Please answer the following questions and sign.**

Q1. Is the patient 17 years of age or older?

☐ Yes ☐ No

Q2. Is the prescribing physician either a sleep specialist or a neurologist?

☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis of narcolepsy? Please attach sleep study

☐ Yes ☐ No

Q4. Does the patient have a confirmed diagnosis of shift work disorder? Please attach chart notes supporting diagnosis.

☐ Yes ☐ No

Q5. Does the patient have obstructive sleep apnea? Please attach sleep study.

☐ Yes ☐ No

Q6. Requested Duration:

☐ 12 Months

Q7. Additional Information:

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| **Patient Name:** | **Prescriber Name:** |
|---|---|

Prescriber Signature Date

2023 Medicare Prior Authorization Request