## 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.

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 the life or health of the enrollee or the enrollee's ability to	pox and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize oregain maximum function.
Drug Name:	
Strength:	
Directions / SIG:	
Please attach any pertinent medical hi	story including labs and information for this member that may support approval.
* •	ase answer the following questions and sign.
Q1. Is the patient 17 years of age or old	er?
☐ 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.	diagnosis of shift work disorder? Please attach chart notes supporting
☐Yes	□ No
Q5. Does the patient have obstructive s	leep apnea? Please attach sleep study.
☐ Yes	□ No
Q6. Requested Duration:	
12 Months	
Q7. Additional Information:	

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

Patient Name:	Prescriber Name:
Prescriber Signature	Date

2023 Medicare Prior Authorization Request