

**Wakix (pitolisant)**  
**Prior Authorization Request Form**  
 Caterpillar Prescription Drug Benefit  
 Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** \_\_\_\_\_ **MEMBER'S FIRST NAME:** \_\_\_\_\_

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

**URGENT**

MEMBER INFORMATION	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PHONE NUMBER:</b>	<b>DATE OF BIRTH:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:                      ZIP CODE:</b>
<b>PATIENT INSURANCE ID NUMBER:</b>	

**MALE**    **FEMALE**   **HEIGHT (IN/CM):** \_\_\_\_\_   **WEIGHT (LB/KG):** \_\_\_\_\_   **ALLERGIES:** \_\_\_\_\_

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [PRIMETHERAPEUTICS.COM/NOPP](http://PRIMETHERAPEUTICS.COM/NOPP)**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** \_\_\_\_\_  
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** \_\_\_\_\_

PRESCRIBER INFORMATION	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PRESCRIBER SPECIALTY:</b>	<b>EMAIL ADDRESS:</b>
<b>NPI NUMBER:</b>	<b>DEA NUMBER:</b>
<b>PHONE NUMBER:</b>	<b>FAX NUMBER:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:                      ZIP CODE:</b>
<b>REQUESTER (if different than prescriber):</b>	<b>OFFICE CONTACT PERSON:</b>

MEDICATION OR MEDICAL DISPENSING INFORMATION			
<b>MEDICATION NAME:</b>			
<b>DOSE/STRENGTH:</b>	<b>FREQUENCY:</b>	<b>LENGTH OF THERAPY/REFILLS:</b>	<b>QUANTITY:</b>
<input type="checkbox"/> <b>NEW THERAPY</b> <input type="checkbox"/> <b>RENEWAL</b>		<b>IF RENEWAL: DATE THERAPY INITIATED:</b>	
<b>DURATION OF THERAPY (SPECIFIC DATES):</b>			

*Continued on next page*



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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?		
<input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY</b> (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Excessive Daytime Sleepiness (EDS) in <b>Pediatric</b> Patients with Narcolepsy <input type="checkbox"/> Cataplexy with narcolepsy in <b>Pediatric</b> patients <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s):		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<b>Is patient going to be using drug in combination with a clinical trial?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Does the patient have a diagnosis of narcolepsy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>  <b>Does the patient have narcolepsy with associated cataplexy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit chart notes or consultation report documenting diagnosis.</i>  <b>Has the patient had a sleep study to affirm a diagnosis of narcolepsy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit submitted copy of the polysomnography (PSG) sleep study results consistent with narcolepsy including submission of The Multiple Sleep Latency Test consistent with narcolepsy.</i>  <b>Does the patient have an Epworth Sleepiness Scale (ESS) score of 14 or greater?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>  <b>Does the patient have another primary cause of excessive daytime sleepiness (such as a sleep Apnea Index <math>\geq</math> 10 per hour and/or an Apnea/Hypopnea Index <math>\geq</math> 15 per hour, periodic limbs movement (PLM) disorders as defined by a PLM arousal index (PLMAI) <math>\geq</math> 10 per hour, shift work, chronic sleep deprivation, circadian sleep wake rhythm disorder)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Will the patient take Wakix while also taking modafinil, armodafinil or any amphetamine product?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?</b>  <hr/> <hr/>		
<b>Please note:</b> Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.		



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**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO:** 800-424-7640  
**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program  
Attn: CP-4201  
P.O. Box 64811  
St. Paul, MN 55164-0811  
**Phone:** 877-228-7909