

US Family Health Plan
Prior Authorization Request Form for
pitolisant (**Wakix**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior Authorization expires after 1 year

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Does the patient have a documented diagnosis of excessive daytime sleepiness associated with narcolepsy ² ?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Has narcolepsy been diagnosed by polysomnography or mean sleep latency time (MSLT) objective testing?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Have other causes of sleepiness been ruled out or treated (including but not limited to obstructive sleep apnea)?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Is the requested medication being prescribed by a neurologist, psychiatrist, or sleep medicine specialist?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Will the patient be taking modafinil, armodafinil, or stimulant-based therapy, such as amphetamine or methylphenidate with the requested medication?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 7
7. Does the patient have a history of severe hepatic impairment?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 8

Prior Authorization Request Form for
pitolisant (**Wakix**)

8. Has the patient tried and failed, by having an inadequate response, modafinil?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Has the patient tried and failed, by having an inadequate response, armodafinil?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. Has the patient tried and failed, by having an inadequate response, stimulant based therapy (amphetamine or methylphenidate)?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
11. Is the patient pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

² Coverage is not approved for use in non-FDA approved conditions, including the following: including but not limited to fibromyalgia, insomnia, excessive sleepiness not associated with narcolepsy, cataplexy, obstructive sleep apnea, major depression, ADHD, or shift work disorder.

Step I certify the above is true to the best of my knowledge. Please sign and date:

3

Prescriber Signature

Date

[19 February 2020]