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 855-273-5735

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. Does the provider acknowledge that a prior authorization is not required for modafinil or armodafinil?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient a child, adolescent, or pregnant patient?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a documented diagnosis of excessive daytime sleepiness associated with narcolepsy and/or cataplexy [2]?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have narcolepsy and an Epworth Sleepiness Scale (ESS) score greater than or equal 14?	☐ Yes Proceed to question **6**	☐ No Proceed to question **7**
6. Has narcolepsy been diagnosed by polysomnography or mean sleep latency time (MSLT) objective testing?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
7. Does the patient have cataplexy and an Epworth Sleepiness Scale (ESS) score of greater than or equal to 12?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have at least 3 cataplexies per week?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

9. Have other causes of sleepiness been ruled out or treated (including but not limited to obstructive sleep apnea)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the requested medication being prescribed by a neurologist, psychiatrist, or sleep medicine specialist?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient be taking modafinil, armodafinil, or stimulant-based therapy, such as amphetamine or methylphenidate with the requested medication?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Has the patient tried and failed and had an inadequate response to modafinil?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Has the patient tried and failed and had an inadequate response to armodafinil?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Has the patient tried and failed and had an inadequate response to stimulant based therapy (amphetamine or methylphenidate)?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Does the patient have a history of severe hepatic impairment?	☐ Yes **STOP** **Coverage not approved**	☐ 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, obstructive sleep apnea, major depression, ADHD, or shift work disorder.

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date