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	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **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: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): ____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: ____

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

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY**	☐ **RENEWAL**	**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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Magellan Rx MANAGEMENT

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Excessive Daytime Sleepiness (EDS) in Adult Patients with Narcolepsy □ Cataplexy in Adult Patients with Narcolepsy □ Other diagnosis: ___________________________ICD-10________________________	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Excessive Daytime Sleepiness (EDS) in Adult Patients with Narcolepsy

Does the patient have a diagnosis of narcolepsy? □ **Yes** □ **No** ***Please submit documentation.***

Does the patient have narcolepsy with associated cataplexy? □ **Yes** □ **No** ***Please submit documentation.***

Has the patient had a sleep study to affirm a diagnosis of narcolespy? □ **Yes** □ **No** ***Please submit documentation.***

Does the patient have an Epworth Sleepiness Scale (ESS) score of 14 or greater?
□ **Yes** □ **No** ***Please submit documentation.***

Does the patient have another primary cause of excessive daytime sleepiness (such as a sleep Apnea Index ≥ 10 per hour and/or an Apnea/Hypopnea Index ≥ 15 per hour, periodic limbs movement (PLM) disorders as defined by a PLM arousal index (PLMAI) ≥ 10 per hour, shift work, chronic sleep deprivation, circadian sleep wake rhythm disorder)? □ **Yes** □ **No**

Has the patient had a prior trial of modafinil or armodafinil? □ **Yes** □ **No** ***Please submit documentation.***

Will the patient take Wakix while also taking modafinil, armodafinil or any amphetamine product? □ **Yes** □ **No**

Cataplexy in Adult Patients with Narcolepsy

Is the prescriber a sleep specialist or neuroligst? □ **Yes** □ **No**

Has the patient had a polysomnography (PSG) sleep study to affirm a diagnosis of narcolespy?
□ **Yes** □ **No** ***Please submit documentation.***

Does the patient have a diagnosis of narcolepsy with cataplexy? □ **Yes** □ **No** ***Please submit documentation.***

Has the patient had a Multiple Sleep Latency Test to affirm a diagnosis of narcolespy?
□ **Yes** □ **No** ***Please submit documentation.***

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

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:** ________________

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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