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# New Hampshire Medicaid Fee-for-Service Program
# Prior Authorization Drug Approval Form

Wakix® (pitolisant)

**DATE OF MEDICATION REQUEST: / /**

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

**LAST NAME:**

**FIRST NAME:**

**MEDICAID ID NUMBER:**

**DATE OF BIRTH:** – –

**GENDER:** ☐ Male ☐ Female

**Drug Name:**

**Strength:**

**Dosing Directions:**

**Length of Therapy:**

## SECTION II: PRESCRIBER INFORMATION

**LAST NAME:**

**FIRST NAME:**

**SPECIALTY:**

**NPI NUMBER:**

**PHONE NUMBER:** – –

**FAX NUMBER:** – –

## SECTION III: CLINICAL HISTORY:

1. Is the prescriber a sleep specialist or neurologist or has one been consulted? ☐ Yes ☐ No
2. Does the patient have a diagnosis of narcolepsy according to DSM-5 or ICSD-3? ☐ Yes ☐ No
3. Does the patient have excessive daytime sleepiness associated with narcolepsy confirmed by sleep testing? (Check all that apply.)
   - ☐ Polysomnography
   - ☐ Multiple sleep latency test
4. Does the patient have any of the following? (Check all that apply.)
   - ☐ Obstructive sleep apnea
   - ☐ Delayed sleep phase disorder
   - ☐ Substance or medication side effect or withdrawal

**Phone**: 1-866-675-7755
**Fax**: 1-888-603-7696

Review Date:12/04/2024

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**PATIENT LAST NAME:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

**PATIENT FIRST NAME:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

**SECTION III: CLINICAL HISTORY *(Continued)***

5. Does the patient have daily periods of an irrepressible need to sleep or daytime lapses into sleep occurring for 3 or more months? ☐ Yes ☐ No

6. Has the patient tried at least 30 days of a central nervous system (CNS) stimulant (e.g., methylphenidate)? ☐ Yes ☐ No

   Details of trial: _____

   If no, provide reason: _____

7. Has the patient tried at least 30 days of a CNS promoting wakefulness drug (e.g., modafinil)? ☐ Yes ☐ No

   Details of trial: _____

   If no, provide reason: _____

8. Are sleep logs for the last 30 days attached to this request? ☐ Yes ☐ No

9. Provide any additional information that would help in the decision-making process.
   If additional space is needed, please use a separate sheet.

**I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

**PRESCRIBER'S SIGNATURE**: _____ **DATE**: _____

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