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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.) If the request is for **cataplexy** associated with narcolepsy skip to question 9. ☐ Yes ☐ No
   - ☐ 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

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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. Does the patient have **cataplexy** associated with narcolepsy confirmed by sleep testing? (Check all that apply.) ☐ Yes ☐ No

   ☐ Polysomnography

   ☐ Multiple sleep latency test

10. Does the patient have any of the following? (Check all that apply.)

    ☐ Epilepsy

    ☐ Syncope

    ☐ Other neurologic condition that may cause cataplexy

11. Has the patient tried at least 30 days of a drug to treat cataplexy? ☐ Yes ☐ No

    Details of trial: _____

    If no, provide reason: _____

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

13. **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**: _____