



**New Hampshire AIDS Drug Assistance 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:

- Is the prescriber a sleep specialist or neurologist or has one been consulted? Yes No
- Does the patient have a diagnosis of narcolepsy according to DSM-5 or ICSD-3? Yes No
- Does the patient have excessive daytime sleepiness associated with narcolepsy confirmed by sleep testing? (Check all that apply.)
 - Polysomnography
 - Multiple sleep latency test
- 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



New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form
 Wakix® (pitolisant)

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:** _____