

New Hampshire AIDS Drug Assistance Program

Prior Authorization Drug Approval Form

Wakix[®] (pitolisant)

DATE OF MEDICATION REQUEST: / /

SEC	τιοι	N I: P	ATIE		NFO	RMA	ΓΙΟΝ) ME	DIC	ATION	REC	QUE	STED)									
LAST NAME:								FI	FIRST NAME:															
MEDICAID ID NUMBER:								D	DATE OF BIRTH:															
															_] _						
GEN	IDER	:			Тм	ale			Fema	ale								J						
Drug Name:									Strength:															
Dosing Directions:									Length of Therapy:															
SEC	TIOI	N II: F	PRES	CRIB	BER II	NFOR	MA	ΓΙΟΝ																
LAS	AST NAME:								FI	FIRST NAME:														
SPECIALTY:						N	NPI NUMBER:																	
PHONE NUMBER:								F/	FAX NUMBER:															
] –				- [] –] –				
SEC		N III:	CLIN	ICAL	. HIST	FORY	:																	
1.	ls th	e pre	escril	ber a	slee	p spe	ciali	st or	neu	rolog	gist or	has d	one	bee	n cor	nsulte	ed?				[Y	es [No
2.	Doe	s the	pati	ent ł	nave	a dia	gnos	is of	narc	olep	sy acc	ordi	ng t	o DS	M-5	or IC	SD-3	?			[Y	es [_ No
3.	Doe slee	s the p tes Polys	pati ting omn	ent ł ? (Ch ogra	nave eck a phy		ssive It ap	day		-	, piness		-						nfirm	ed by	,			
4.			-	-		-		≏ foll	owin	ng? ((^heck	all tł	nat a	annlı	()									
ч.		Does the patient have any of the following? (Check all that apply.)																						
	\equiv				-	se dis		r																
		-		-	-				ect ດ	or wit	hdrav	val												
Pho		-800-									nagen		LLC.	All r	ights	resei	ved.				Ma	gel	lan	Rx





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PA	TIENT LAST NAME:	PATIENT FIRST NAME:										
SE	SECTION III: CLINICAL HISTORY (Continued)											
5.	Does the patient have daily periods of an irrepressible sleep occurring for 3 or more months?	nto		Yes [_ No							
6. Has the patient tried at least 30 days of a central nervous system (CNS) stim methylphenidate)?									Yes [No		
	Details of trial:	_										
	If no, provide reason:		_									
7.	Has the patient tried at least 30 days of a CNS promotion Details of trial:		Yes [_ No								
	If no, provide reason:		_									
									_			
8.	Are sleep logs for the last 30 days attached to this requ	uest?							Yes	No		
9.	Provide any additional information that would help in t If additional space is needed, please use a separate she		on-ma	king	proce	SS.						

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: _____

