HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
WAKIX®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Wakix® (pitolisant)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
Excessive Daytime Sleepiness Associated with Narcolepsy			
1. Does the member have a baseline Epworth Sleepiness Scale (ESS) score of ≥ 15?	☐	☐	Please provide documentation
2. Does the member have a diagnosis of narcolepsy confirmed by polysomnography and Multiple Sleep Latency Test (MSLT)?	☐	☐	Please provide documentation
3. Is the medication prescribed by, or in consultation with, a sleep disorder specialist or neurologist?	☐	☐	Please provide documentation
4. Does the member have at least a 3-month trial and failure or contraindication/intolerance to Sunosi® (solriamfetol)?	☐	☐	Please provide documentation
5. Does the member have at least a 3-month trial and failure or contraindication/intolerance to at least one agent from each of the following categories: • A central nervous system stimulant such as methylphenidate • A wakefulness promoting agent such as modafinil	☐	☐	Please provide documentation
6. Does the member have adequately controlled blood pressure?	☐	☐	Please provide documentation
7. Will the member be monitored for psychological disorders or exacerbations?	☐	☐	Please provide documentation
CATAPLEXY IN PATIENTS WITH NARCOLEPSY			
1. Does the member have a diagnosis of narcolepsy confirmed by polysomnography and Multiple Sleep Latency Test (MSLT)?	☐	☐	Please provide documentation

2. Is the medication prescribed by, or in consultation with, a sleep disorder specialist or neurologist?	☐	☐	Please provide documentation
3. Has the member tried at least one agent from each of the following categories for at least 3 months each: • A tricyclic antidepressant such as amitriptyline • A selective serotonin reuptake inhibitor (SSRI) such as fluoxetine	☐	☐	Please provide documentation
4. Does the member have adequately controlled blood pressure?	☐	☐	Please provide documentation
5. Will the member be monitored for psychological disorders or exacerbations?	☐	☐	Please provide documentation
REAUTHORIZATION			
1. Does clinical documentation show a continued need for the medication as well as a documented improvement from baseline?	☐	☐	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy PHARM-125
Origination Date: 07/22/2019
Reviewed/Revised Date: 01/19/2022
Next Review Date: 01/19/2023
Current Effective Date: 02/01/2022