Prior Authorization Request Form for
pitolisant (**Wakix**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.
Prior Authorization expires after 1 year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: _____ Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. **Does the provider acknowledge that a prior authorization is not required for modafinil or armodafinil?**	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. **Is the patient a child, adolescent, or pregnant patient?**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. **Is the patient greater than or equal to 18 years of age?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. **Does the patient have a documented diagnosis of excessive daytime sleepiness associated with narcolepsy and/or cataplexy [2]?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **Does the patient have an Epworth Sleepiness Scale (ESS) score greater than or equal 14?**	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. **Has narcolepsy been diagnosed by polysomnography or mean sleep latency time (MSLT) objective testing?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. **Have other causes of sleepiness been ruled out or treated (including but not limited to obstructive sleep apnea)?**	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. **Is the requested medication being prescribed by a neurologist, psychiatrist, or sleep medicine specialist?**	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

9. Will the patient be taking modafinil, armodafinil, or stimulant-based therapy, such as amphetamine or methylphenidate with the requested medication?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Has the patient tried and failed and had an inadequate response to modafinil?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has the patient tried and failed and had an inadequate response to armodafinil?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Has the patient tried and failed and had an inadequate response to stimulant based therapy (amphetamine or methylphenidate)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient have a history of severe hepatic impairment?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

[2] Coverage is not approved for use in non-FDA approved conditions, including the following: including but not limited to fibromyalgia, insomnia, excessive sleepiness not associated with narcolepsy, obstructive sleep apnea, major depression, ADHD, or shift work disorder.

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[27 October 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: