AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Wakix

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

1. Is the beneficiary age 18 or older? Yes___ No___
2. Does the beneficiary have daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three (3) months? Yes___ No___
3. Is the beneficiary receiving treatment with sedative hypnotic agents (e.g., zolpidem, eszopiclone, zaleplon, benzodiazepines, barbiturates)? Yes___ No___
4. Will the beneficiary use drugs that prolong the QT interval (e.g., quinidine, procainamide, disopyramide, amiodarone, sotalol, ziprasidone, chlorpromazine, thioridazine, moxifloxacin) concomitantly? Yes___ No___
5. Will the beneficiary use histamine-1 (H1) receptor antagonists (e.g., pheniramine maleate, diphenhydramine, promethazine, imipramine, clomipramine, mirtazapine) concomitantly? Yes___ No___
6. Does the beneficiary have a history of prolonged QTc interval (e.g., QTc interval > 450 milliseconds)? Yes___ No___
7. Does the beneficiary have end-stage renal disease (estimated glomerular filtration rate [eGFR] < 15 mL/min/1.73 m2)? Yes___ No___
8. Does the beneficiary have severe hepatic impairment? Yes___ No___
9. Does the beneficiary have a diagnosis of cataplexy with narcolepsy? Yes___ No___
10. Does the beneficiary have a diagnosis of narcolepsy? Yes___ No___
11. Does the beneficiary have an adequate documented trial and failure of, or contraindication to, modafinil and armodafinil? Yes___ No___ Please explain if contraindicated:_____
_____

For continuation of therapy, please answer questions 1-14

12. If treating narcolepsy, has the beneficiary reported a documented reduction in excessive daytime sleepiness from pre-treatment baseline as measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)? Yes___ No___
13. If treating cataplexy with narcolepsy, has the beneficiary had reduced frequency of cataplexy attacks from pretreatment baseline? Yes___ No___
14. Has the beneficiary experienced any treatment-restricting adverse effects (e.g., abnormal behavior, abnormal dreams or nightmares, anhedonia, anxiety, bipolar disorder, depression or depressed mood, nausea, QT prolongation, sleep disorder, suicide attempt or suicidal ideation)? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

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.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406