

WAKIX
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Excessive daytime sleepiness associated with narcolepsy <input type="checkbox"/> Excessive daytime sleepiness or cataplexy associated with narcolepsy <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently being treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindications: _____ _____ 3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., neurologist, psychiatrist, sleep disorder specialist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Is the patient's age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age for the requested indication: _____ _____ 5. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? Please note, chart notes are required. <input type="checkbox"/> Yes <input type="checkbox"/> No 7. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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5. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

6. Has the patient been prescribed the requested non-controlled agent due to comorbid conditions OR concerns about controlled substance use? Yes No

7. Has the patient tried and had an inadequate response to armodafinil OR modafinil? Yes No

8. Was armodafinil OR modafinil discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

9. Is armodafinil OR modafinil is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?..... Yes No

10. Is armodafinil OR modafinil not in the best interest of the patient based on medical necessity? Yes No

11. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as armodafinil OR modafinil and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

12. Does the patient have an intolerance or hypersensitivity to armodafinil OR modafinil? Yes No
If yes, please explain intolerance/hypersensitivity: _____

13. Does the patient have an FDA labeled contraindication to BOTH armodafinil AND modafinil? Yes No
If yes, please specify contraindication: _____

For renewal requests:

14. Has the patient had clinical benefit with the requested agent? Yes No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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