Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Wakix (Pitolisant) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Wakix (Pitolisant) (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
WAKIX 17.8 MG TABLET	WAKIX 4.45 MG TABLET

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of cataplexy in the last 730 days? Y N
   If the answer to this question is yes, go to question 6.
   If the answer to this question is no, go to question 4.

4. Does the patient have a diagnosis of narcolepsy in the last 730 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the patient have at least 30 days therapy of modafinil or armodafinil in the last 90 days? Y N

If the answer to this question is yes, go to question 6.
If the answer to this question is no, denied.

6. Does the patient have a diagnosis of hepatic impairment in the last 365 days? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, go to question 7.

7. Does the patient have a diagnosis of end stage renal disease (ESRD) in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 8.

8. Does the patient have a diagnosis of moderate to severe renal impairment in the last 365 days? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, go to question 10.

9. Is the requested dose less than or equal to 17.8 mg daily? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, denied.

10. Is the requested dose less than or equal to 35.6 mg daily? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, denied.

11. Is the medication being requested by, or in consultation with, a specialist (psychiatrist, neurologist, sleep specialist) OR has the patient had a sleep study with a sleep latency test? Y N
If the answer to this question is yes, go to question 12.
If the answer to this question is no, denied.

12. Is the request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 13.
If the answer to this question is no, approved for 365 days.

13. Has the patient failed a treatment trial with at least 1 preferred agent? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 14.

14. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 15.

15. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date