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NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Antinarcolepsy: Wakix

Beneficiary Information

1. Beneficiary Last Name: _____2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information –
Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days):

☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

1. Is the beneficiary 18 years 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**

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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 **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**