DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02573 (01/2020)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR WAKIX

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Wakix Instructions, F-02573A. Providers may refer to the Forms page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Wakix form signed by the prescriber before submitting a prior authorization request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Member ID Number	3. Date of Birth – Member

SECTION II – PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Directions for Use

8. Refills

9. Name – Prescriber	10. National Provider Identifier – Prescriber

11. Address – Prescriber (Street, City, State, Zip+4 Code)

12. Phone Number – Prescriber

SECTION III – CLINICAL INFORMATION

Note: A copy of the member's current medical records that support a clinical correlation between the member's test results and the member's condition of excessive daytime sleepiness (EDS) associated with narcolepsy needs to be submitted with the prior authorization request, including the following:

- Test results and provider interpretation for the overnight polysomnogram and multiple sleep latency test (MSLT)
- A copy of the Epworth sleepiness scale questionnaire, maintenance of wakefulness test, or MSLT confirming that the member has EDS
- For renewal requests, medical records documentation demonstrating clinical improvement, including a decrease in the member's EDS, which is supported by an Epworth sleepiness scale questionnaire, maintenance of wakefulness test, or MSLT

13. Diagnosis Code and Description

14. Does the member have narcolepsy? ☐ Yes ☐ No

15. Is the member 18 years of age or older? ☐ Yes ☐ No

16. Has the prescriber reviewed the member's current medication list to evaluate for potential drug interactions (for example, cytochrome P450 2D6 [CYP2D6] inhibitors, cytochrome P450 3A4 [CYP3A4] inducers, and drugs that increase the QT interval)? ☐ Yes ☐ No

17. Is the member currently taking any sedative hypnotics? ☐ Yes ☐ No

18. Is the member currently taking central nervous system depressants (for example, anxiolytics, barbiturates, or opioids)? ☐ Yes ☐ No

If yes, indicate the central nervous system depressants and daily doses.

1. _____

2. _____

3. _____

Are any of the above listed central nervous system depressants contributing to the member's daytime sleepiness? ☐ Yes ☐ No

If no, indicate how the prescriber evaluated the central nervous system depressants and determined they are not contributing to the member's daytime sleepiness.

19. Has the member had an overnight polysomnogram sleep study followed by an MSLT? ☐ Yes ☐ No

20. Does the member have EDS that interferes with normal activities on a daily basis? ☐ Yes ☐ No

21. Has the member completed an Epworth sleepiness scale questionnaire, maintenance of wakefulness test, or MSLT? ☐ Yes ☐ No

22. Has the prescriber ruled out or treated the member for each of the following potential causes of EDS? ☐ Yes ☐ No
- Other sleep disorders including sleep apnea
- Chronic pain or illness that disrupts normal sleep patterns
- Mood disorders such as depression
- Caffeine or nicotine use causing poor quality of nighttime sleep

23. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant? ☐ Yes ☐ No

If yes, list the stimulant and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the stimulant was taken in the space provided.

24. Does the member have a medical condition(s) that prevents treatment with a stimulant? ☐ Yes ☐ No

If yes, list the medical condition(s) that prevents treatment with a stimulant in the space provided.

25. Is there a clinically significant drug interaction between another medication the member is taking and stimulants? ☐ Yes ☐ No

If yes, list the medication(s) and interaction(s) in the space provided.

26. Has the member experienced an unsatisfactory therapeutic response after the medication has been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction with armodafinil or modafinil? ☐ Yes ☐ No

If yes, list the drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates armodafinil or modafinil was taken in the space provided.

27. Does the member have a medical condition(s) that prevents treatment with armodafinil or modafinil? ☐ Yes ☐ No

If yes, list the medical condition(s) that that prevents treatment with armodafinil or modafinil in the space provided.

28. Is there a clinically significant drug interaction between another medication the member is taking and armodafinil or modafinil? ☐ Yes ☐ No

If yes, list the medication(s) and interaction(s) in the space provided.

SECTION IV – AUTHORIZED SIGNATURE	
29. **SIGNATURE** – Prescriber	30. Date Signed

SECTION V – ADDITIONAL INFORMATION

31. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

Reset Form