**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-02573 (10/2024)

**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 (PA) request on the Portal, by fax, or by mail. Providers may call Provider Services at 800‑947‑9627 with questions.

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| **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 medical condition of narcolepsy with cataplexy or narcolepsy without cataplexy must be submitted with the PA request, including the following:* Test results and provider interpretation for the overnight polysomnogram (PSG) and Multiple Sleep Latency Test (MSLT)
* For members with excessive daytime sleepiness (EDS), a copy of the Epworth Sleepiness Scale (ESS) questionnaire, Maintenance of Wakefulness Test (MWT), or MSLT
* For renewal PA requests, medical record documentation demonstrating clinical improvement, including a decrease in cataplexy or a decrease in the member’s EDS supported by an ESS questionnaire, MWT, or MSLT
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| 13. Diagnosis Code and Description      |



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| 14. Does the member have narcolepsy with cataplexy? [ ]  Yes [ ]  NoIf yes, indicate the cataplexy symptoms experienced by the member and how frequently they occur.      |
| 15. Does the member have narcolepsy without cataplexy? [ ]  Yes [ ]  No |
| 16. Has the prescriber reviewed the member’s current medication list to evaluatefor 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. Indicate which symptom(s) of narcolepsy Wakix is being used to treat.[ ]  Cataplexy[ ]  EDS[ ]  Other       |
| 18. Is the member taking any sedative hypnotics? [ ]  Yes [ ]  No |
| 19. Is the member taking central nervous system (CNS) depressants (for example, anxiolytics, barbiturates, or opioids)? [ ]  Yes [ ]  No If yes, indicate the CNS depressants and daily doses.1.      2.      3.      Are any of the above listed CNS depressants contributing to the member’sdaytime sleepiness? [ ]  Yes [ ]  NoIf no, indicate how the prescriber evaluated the CNS depressants and determined they are not contributing to the member’s daytime sleepiness.       |
| 20. Has the member had an overnight PSG sleep study followed by an MSLT? [ ]  Yes [ ]  No |
| 21. Does the member have EDS that interferes with normal activitieson a daily basis? [ ]  Yes [ ]  No |
| 22. Has the member completed an ESS questionnaire, MWT, or MSLT? [ ]  Yes [ ]  No |
| 23. 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
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| 24. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant? [ ]  Yes [ ]  NoIf 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.      |
| 25. Does the member have a medical condition(s) that prevents treatment with a stimulant? [ ]  Yes [ ]  NoIf yes, list the medical condition(s) that prevents treatment with a stimulant in the space provided.      |
| 26. Is there a clinically significant drug interaction between another medication the member is taking and stimulants? [ ]  Yes [ ]  NoIf yes, list the medication(s) and interaction(s) in the space provided.      |
| 27. Has the member experienced an unsatisfactory therapeutic response after the medication has been titrated to a maximum recommended daily dose or experienceda clinically significant adverse drug reaction with armodafinil or modafinil? [ ]  Yes [ ]  NoIf 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.      |
| 28. Does the member have a medical condition(s) that prevents treatment with armodafinil or modafinil? [ ]  Yes [ ]  NoIf yes, list the medical condition(s) that that prevents treatment with armodafinil or modafinil in the space provided.      |
| 29. Is there a clinically significant drug interaction between another medication the member is taking and armodafinil or modafinil? [ ]  Yes [ ]  NoIf yes, list the medication(s) and interaction(s) in the space provided.      |
| 30. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI), or serotonin norepinephrine reuptake inhibitor (SNRI)? [ ]  Yes [ ]  NoIf yes, list the TCA, SSRI, or SNRI, the dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the TCA, SSRI, or SNRI was taken in the space provided.      |
| **SECTION IV – AUTHORIZED SIGNATURE** |
| 31. **SIGNATURE** –Prescriber | 32. Date Signed |
| **SECTION V – ADDITIONAL INFORMATION** |
| 33. 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.      |