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 this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
   ☐ **Yes** ☐ **No**
2. Is the beneficiary age 18 or older? ☐ **Yes** ☐ **No**
3. Does the beneficiary have an adequate documented trial and failure of, or contraindication to, modafinil and armodafinil?
   ☐ **Yes** ☐ **No** Please explain if contraindicated: _____
4. Does the beneficiary have a diagnosis of narcolepsy? ☐ **Yes** ☐ **No**
5. 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**
6. Is the beneficiary receiving treatment with sedative hypnotic agents (e.g., zolpidem, eszopiclone, zaleplon, benzodiazepines, and barbiturates)? ☐ **Yes** ☐ **No**
7. Will the beneficiary use drugs that prolong the QT interval (e.g., quinidine, procainamide, disopyramide, amiodarone, sotalol, ziprasidone, chlorpromazine, thioridazine, moxifloxacin) concomitantly? ☐ **Yes** ☐ **No**
8. Will the beneficiary use histamine-1 (H1) receptor antagonists (e.g., pheniramine maleate, diphenhydramine, promethazine, imipramine, clomipramine, mirtazapine) concomitantly? ☐ **Yes** ☐ **No**
9. Does the beneficiary have a history of prolonged QTc interval (e.g., QTc interval > 450 milliseconds)? ☐ **Yes** ☐ **No**
10. Does the beneficiary have end-stage renal disease (estimated glomerular filtration rate [eGFR] < 15 mL/min/1.73 m2)?
    ☐ **Yes** ☐ **No**
11. Does the beneficiary have sever hepatic impairment? ☐ **Yes** ☐ **No**

For continuation of therapy, please answer questions 1-14

12. 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. 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 CSRA at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505

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