Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of Wakix (pitolisant)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	Prescriber Fax:
Prescriber Name/Specialty if applicable:	Dose Requested:	

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

- Member is ≥18 years of age: ☐ Yes ☐ No (required)
- Member must have a diagnosis of narcolepsy with excessive daytime sleepiness (EDS) that impacts activities of daily living: ☐ Yes ☐ No
- Member has had an inadequate response, intolerance to, or contraindication to ALL of the following:
  - ☐ CNS stimulant (i.e., methylphenidate, dextroamphetamine, etc). Drug_____Date: _____
  - ☐ Modafinil OR ☐ Armodafinil Date: _____
  - ☐ Sunosi Date: _____

☐ Provider acknowledges the member has been assessed for the following clinically significant drug interactions*:

Category	Clinical Implication	Prevention/Management	Examples
Strong CYP2D6 Inhibitors	↑ exposure to pitolisant by 2.2-fold	Reduce Wakix dose by half	Paroxetine, fluoxetine, bupropion
Strong CYP3A4 Inducers	â exposure of pitolisant by 50%	Assess for loss of efficacy and consult package insert for Wakix dosing adjustments	Rifampin, carbamazepine, phenytoin
Histamine-1 (H1) Receptor Antagonists	↑ brain histamine levels	Avoid centrally acting H1 receptor antagonists	Pheniramine, diphenhydramine, promethazine, imipramine, clomipramine, mirtazapine
QT Interval Prolonging Medications	Additive QT prolongation/↑ arrhythmia risk	Avoid with drugs known to prolong QT interval	Quinidine, procainamide, disopyramide, amiodarone, sotalol, ziprasidone, chlorpromazine, thioridazone, moxifloxacin
Sensitive CYP3A4 Substrates	âeffectiveness of substrate	Use alternative contraceptive during tx and 21 days after DC	Midazolam, hormonal contraceptives, cyclosporine

*Consult package insert for complete drug interaction information

LIMITATIONS: Maximum of 35.6mg per day (dose optimization required). **Initial authorization will be issued for 6 months.**

☐ CONTINUATION OF THERAPY

Provider attests member has achieved a clinically meaningful response to treatment ☐ Yes ☐ No

Reauthorization will be issued for 12 months.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit at 1-800-294-1350