Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Wakix® (pitolisant)
Medications Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select all that apply:

- ❑ The recipient has a diagnosis of narcolepsy as confirmed by a sleep study.
- ❑ The recipient has a diagnosis of narcolepsy, but a sleep study is not feasible (provide justification below).
- ❑ The recipient is 18 years of age or older.

Recertification:

- ❑ The recipient has a documented positive clinical response to Wakix® therapy.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.