Wakix Enrollment Form

Fax Referral To: 855-297-1270
Phone: 1-888-280-1190 or 787-759-4162
Email Referral To: Customer.ServiceFax@CVSHealth.com
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____
City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____ Email: _____
Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening Last Four of SSN: _____ Primary Language: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First):
_____ **Relationship to minor**: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ Group or Hospital: _____
Address: _____
City, State, ZIP Code: _____ Phone: _____
Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name: _____ Policy Holder's DOB: _____
Relationship to Patient: _____Medical Insurance: _____ Telephone: _____
Policy ID: _____ Group #: _____ Prescription Insurance: _____
Prescription Plan Telephone: _____ Policy ID: _____
Group #: _____ RX BIN #: _____ RX PCN #: _____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Patient Clinical Information:
Needs by date: _____ Allergies: _____
Has patient previously been treated for Narcolepsy? ☐ Yes ☐ No If YES, list all previous medications:
_____
List concomitant medications (e.g., stimulants, sodium oxybate):_____
_____

Diagnosis (ICD-10):	
☐ G47.41 Narcolepsy	☐ G47.42 Narcolepsy in conditions classified elsewhere
☐ G47.411 Narcolepsy with cataplexy	☐ G47.421 Narcolepsy in conditions classified elsewhere w/ cataplexy
☐ G47.419 Narcolepsy without cataplexy	☐ Other Code: ____ Description _____

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

Titration to and Maintenance dose of 17.8mg

MEDICATION	STRENGTH, QUANTITY/REFILLS	DOSE & DIRECTIONS
☐ Wakix (pitolisant) oral tablets	4.45 mg tablet #14 17.8 mg tablet #23 Refills: None	☐ *Titration Dose:* Take 8.9 mg (two x 4.45mg tabs) by mouth once daily in the morning, upon awakening x 7 days; then take 17.8 mg (one x 17.8mg tabs) by mouth once daily in the morning, upon awakening x 23 days
☐ Wakix (pitolisant) oral tablets	17.8mg tablet #30 Refills: _____	☐ *Maintenance Dose:* Take 17.8 mg (one 17.8mg tablet) by mouth once daily in the morning, as soon as you wake up

Titration to and Maintenance dose of 35.6mg

MEDICATION	STRENGTH, QUANTITY/REFILLS	DOSE & DIRECTIONS
☐ Wakix (pitolisant) oral tablets	4.45mg tablet #14 17.8mg tablet #39 Refills: None	☐ *Titration Dose:* Take 8.9 mg (two x 4.45mg tabs) by mouth once daily in the morning, upon awakening x 7 days; then take 17.8 mg (one x 17.8mg tabs) by mouth once daily in the morning, upon awakening x 7 days; then increase to take 35.6 mg (two x 17.8mg tabs) by mouth once daily in the morning, upon awakening x 16 days
☐ Wakix (pitolisant) oral tablets	17.8mg tablet #60 Refills: _____	☐ *Maintenance Dose:* Take 35.6 mg (two 17.8mg tablets) by mouth once daily in the morning, as soon as you wake up

Non-Standard Dosing

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Wakix (pitolisant) oral tablets	☐ _____	☐ Other: _____ _____ _____	Quantity: _____ Refills: _____
☐ Wakix (pitolisant) oral tablets	☐ _____	☐ Other: _____ _____ _____	Quantity: _____ Refills: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written"/Brand Medically Necessary/ Do Not Substitute/No Substitution/DAW/May Not Substitute **Prescriber's Signature: _____ Date: _____**	May Substitute/Product Selection Permitted/Substitution Permissible **Prescriber's Signature: _____ Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____

ATTN: New York and Iowa providers, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty® Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.