WAKIX Prescription Referral Form

Fax completed form to 1-855-635-8520. Phone 1-855-WAKIX4U (1-855-925-4948). Please complete all fields to avoid delays in processing.





PATIENT INFORMATION											
First name: MI:			MI:	Gender:	Μ□F	Address:	Address:				
Last name:				☐ US resident		City:			State:	ZIP:	
Last 4 digits of SSN: DOB: / /						Email:					
Home ph.: ☐ Preferred ☐ OK to leave message						Preferred language other than English:					
Mobile ph.:			Preferred	OK to leave	e message	Alternate contact:			Relationship:		
Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening					Alternate contact ph.:						
FOR PATIENTS UNDER 18 YEARS OF AGE ONLY: PARENT/LEGAL GUARDIAN INFORMATION											
Name: Ph.: Email: Relationship: Parent Legal Guardian											
PATIENT INSURANCE INFORMATION Please attach a copy of the front and back of pati							ent's medical and prescription insurance card(s).				
☐ Patient does not have insurance					Policyholder name: DOB: / /						
Prescription drug insurer:						Relationship to patient: Self Spouse Parent Other:					
Insurer ph.:					Medicare Beneficiary ID #:						
Cardholder ID #:			Grou	ıp #:		Rx BIN #: Rx PCN #:					
PATIENT CONSENT INFORMATION Handwritten signature required.											
Patient Services Authorization (Section A, page 2). Signature and date required for authorization. Parent/Legal Guardian signature required to grant authorization on behalf of patients <18 years of age.						Marketing Authorization Marketing Authorization (Section B, page 2). Signature and date required for authorization. Parent/Legal Guardian signature required to grant authorization on behalf of patients <18 years of age.					
Patient or Parent/Legal Guardian				Date (MM/D	1/DD/YYYY) Patient or Parent/Legal (ardian Date (MM/DD/YYY		(MM/DD/YYYY)	
PRESCRIBER INFO	ORMATION										
First: Last:						Office/Clinic/Institution name:					
NPI #: State license #			ense #:	<i>‡</i> :		Address:					
Office contact name for reimbursement:						City:		State:	ZIP:		
Ph.: Preferred time to call:						Email: Fax:					
DIAGNOSIS CODE (ICD-10)					PATIENT WEIGHT						
☐ G47.411 Narcolepsy with cataplexy ☐ Other (write complete ICD-10 code with diagonal G47.419 Narcolepsy without cataplexy ☐ G47.419 Narcolepsy without cataplexy					diagnosis):	(For patients <18 years of age ONLY) Date Weight: kg			Date (MM/DD	/YYYY): 	
WAKIX® (pitolisant) PRESCRIPTION INFORMATION Check titration prescription, maintenance prescription, or BOTH. See Full Prescribing Information for recommended dosage and dosage modifications.											
ADULT PATIENTS: WAKIX Titration Prescription						Take once daily in the morning, upon wakening					
☐ Titration to 17.8 mg (No refills)				☐ Titration to 35.6 mg (No refills)				☐ Other: (No refills)			
8.9 mg (two 4.45-mg tablets) PO once daily x 7 days #14						s) PO once daily x 7 days #14 Streng			gth:		
17.8 mg (one 17.8-mg tablet) PO once daily x 23 days #23				17.8 mg (one 17.8-mg tablet) PO once daily x 7 days # 35.6 mg (two 17.8-mg tablets) PO once daily x 16 days #				9			
PEDIATRIC PATIENTS (6 years and older): WAKIX Titration Prescription The maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg of the maximum recommended dosage for pediatric patients weighting the maximum recommended dosage f						Take once daily in the morning, upon wakening.					
☐ Titration to 17.8 mg (No refills) ☐ Titration to 35.6 mg						•		☐ Othe	r: (No refills)		
					_	et) PO once daily x 7 days #7 Strength:					
8.9 mg (two 4.45-mg tablets) PO once daily x 7 days #14						s) PO office daily x / days # 14 Cia.					
				17.0 HIU TUHE 17.0-HIU TADIEN EO OHCE UAIIV X / UAVS # / T					tity:		
	DIATRIC (6 years a		NTS: WA	KIX Mainter	ance Pres	scription		once dail	y in the morning	, upon wakening.	
	•			WAKIX 35				☐ Othe	r:		
	g tablet) PO once da	ily x 30 days			_	s) PO once daily	x 30 days #60			Quantity:	
Refills:				Refills:				Sig: _	R	efills:	
PRESCRIBER AUTHORIZATION											
By signing below, I certify that the information provided is complete and accurate to the best of my knowledge, I have prescribed WAKIX based on my judgment of medical necessity, and I will supervise the patient's medical treatment. I authorize Harmony Biosciences and its designated agents and service providers to use and disclose my patient's protected health information as may be necessary for benefits eligibility, coverage authorization and coordination, and dispensing of WAKIX; to contact me regarding prescription status updates; and to act as my prior authorization agent in dealing with prescription and medical insurance providers. I authorize the forwarding of this prescription and information by Harmony Biosciences or its affiliates and their representatives, to a dispensing specialty pharmacy. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.											
Prescriber Signature Date			Date (MM	/DD/YYYY)	» Prescribe	er Signature			Date (MM/DD/YYYY)		
Substitution NOT permitted. Dispense as written.				Substitution permitted.							
Original signature required. Signature stamp not acceptable. CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"											
CA, IVIA, NC & PK	. mierchange is mand	uateu uniess Pres	runei Mill	es me words.	NO SUDSTI	เนเเบท					

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For assistance, call 1-855-WAKIX4U (1-855-925-4948), 8 AM - 8 PM ET, M-F.





PATIENT CONSENT INFORMATION

A. Patient Services Authorization

By signing this Authorization, I, or as Parent/Legal Guardian on behalf of my minor patient ("I"), authorize my physicians or other healthcare providers and staff, my health insurance company, and my pharmacy providers (together, "Providers") to disclose to Harmony Biosciences and its representatives, agents, and contractors working with Harmony Biosciences (together, "Harmony"), my personal health information, including information related to my medical condition, treatment, care management, health insurance coverage and claims, and any other information contained on this treatment form (together, "protected health information").

Specifically, I authorize Harmony to receive, use, and disclose my protected health information to (i) enroll me in and contact me about Harmony medication support programs; (ii) provide me with educational materials, information, and services; (iii) verify, investigate, assist with, and coordinate insurance coverage with my insurers; (iv) coordinate prescription fulfillment and refills; (v) assist with analyses related to the quality, efficacy, and safety of my treatment as well as patient access and adherence; (vi) to share and provide access to information generated by WAKIX for You that may be useful for my care; and (vii) to improve, develop, and evaluate WAKIX for You, its offerings, and materials. I authorize Harmony to contact me to provide such services and information by mail, email, fax, telephone call, and text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), as well as other mutually agreed-upon means.

Once my health information has been disclosed to Harmony, I understand that federal privacy laws no longer protect the information. However, Harmony agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Harmony in exchange for the health information and/or for any support services provided to me. I also authorize disclosure of my health information to the specific individuals whom I have designated on the treatment form.

I understand that I may refuse to sign this Authorization. I further understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. However, if I do not sign the Authorization or later cancel it, I will not be able to receive Harmony's support services. I may cancel this Authorization at any time by writing a letter requesting such cancellation and mailing to WAKIX for You, P.O. Box 15715, Pittsburgh, PA 15244 or by calling WAKIX for You at 1-855-WAKIX4U (1-855-925-4948). Canceling this Authorization will end my consent to further disclosure of my health information to Harmony by my Providers after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. This Authorization expires ten (10) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above.

I understand that I am entitled to receive a copy of this Authorization.

B. Marketing Authorization

I, or as Parent/Legal Guardian on behalf of my minor patient ("I"), authorize Harmony Biosciences and its representatives, agents, and contractors working with Harmony Biosciences (together, "Harmony") to contact me by mail, email, fax, telephone call, and text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice) for marketing purposes or otherwise provide me with information about Harmony's products, services, and programs or other topics of interest, to conduct market research, or to otherwise ask me about my experience with or thoughts about such topics. I understand and agree that any information that I provide may be used by Harmony to help develop new products, services, and programs. I understand that Harmony will not sell or transfer my personal data to any unrelated third party for marketing purposes without my express permission. I understand that I may revoke this Authorization and choose not to receive services or information from Harmony by mailing a letter or calling using the contact information given above or by emailing to privacy@harmonybiosciences.com.

I understand that I am entitled to receive a copy of this Authorization.

For more information about WAKIX and WAKIX for You, call 1-855-WAKIX4U (1-855-925-4948) or visit WAKIX.com

