

WAKIX Prescription Referral Form (Prescription Information)

Be sure to complete all sections on this form.* Incomplete fields may delay the start of treatment.

Fax completed form to 1-855-635-8520.



A Patient Information is required to complete the prescription and for WAKIX for You to be able to contact the patient throughout the process.

Note: If a patient does not want to sign up for WAKIX for You, this information is still required for a valid prescription.

- Complete First name, Last name, Address, City, State, Gender, DOB, and Preferred phone fields.

B Patient Insurance Information is required for WAKIX for You to provide reimbursement support. To process the prescription, indicate whether the patient has insurance.

- If the patient has insurance, the primary medical insurance and ID # fields must be completed.
- Attach a copy of the front and back of the patient's medical and prescription insurance card(s).

C Patient Services Authorization

Request patient signature for the Patient Services Authorization to ensure patients receive full support from WAKIX for You (financial support programs).

See details on next page (C).

D Marketing Authorization

Request patient signature for the Marketing Authorization to enable patient receipt of additional WAKIX materials.

See details on next page (D).

E Prescriber Information

Complete all fields: Prescriber name, NPI #, State license #, Address, City, State, Office contact name, Phone number, Email address, and Fax number. Indicate the preferred time of day to contact your office.

F Diagnosis

A diagnosis code must be provided in order to fill the WAKIX prescription.

G WAKIX Prescription Information

WAKIX Titration Prescription, WAKIX Maintenance Prescription, or BOTH must be selected to fill the WAKIX prescription.

Note: The titration and maintenance doses shown on the form use the recommended dosing from the WAKIX Prescribing Information. Dosage modifications may be required for patients with moderate hepatic impairment, patients with moderate or severe renal impairment, patients known to be poor CYP2D6 metabolizers, and patients receiving concomitant strong CYP2D6 inhibitors or strong CYP3A4 inducers. See Full Prescribing Information for dosage recommendations.

Most treatment-naïve patients will receive both a Titration Prescription and a Maintenance Prescription. Patients who are currently taking WAKIX may receive only a Maintenance Prescription.

H Prescriber Authorization

Prescriber signature and date are required in both signature fields in order to fill the WAKIX prescription.

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.

A PATIENT INFORMATION

First name: _____ MI: _____ Gender: M F 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 message Alternate contact: _____ Relationship: _____
 Best time to reach me: Morning Afternoon Evening Alternate contact phone: _____ OK to leave message

B PATIENT INSURANCE INFORMATION Please attach a copy of the front and back of patient's medical and prescription insurance card(s).

Patient does not have insurance Policyholder name: _____ DOB: _____ / _____ / _____
 Prescription drug insurer: _____ Relationship: Self Spouse Child Other: _____
 Insurer phone: _____ Medicare Beneficiary ID #: _____
 Cardholder ID #: _____ Group #: _____ Rx BIN #: _____ Rx PCN #: _____

C PATIENT CONSENT INFORMATION

Patient Services Authorization I have read and agree to the Patient Services Authorization (Section A, page 2).
 Signature and date required for authorization.

Marketing Authorization I have read and agree to the Marketing Authorization (Section B, page 2).
 Signature and date required for authorization.

» Patient Signature _____ Date (MM/DD/YYYY) _____ Patient Signature _____ Date (MM/DD/YYYY) _____

E PRESCRIBER INFORMATION

Title: _____ First: _____ Last: _____ Office/Clinic/Institution name: _____
 NPI #: _____ State license #: _____ Address: _____
 Office contact name for reimbursement: _____ City: _____ State: _____ ZIP: _____
 Phone: _____ Preferred time to call: _____ Email: _____ Fax: _____

F DIAGNOSIS

Diagnosis (ICD-10): G47.411 Narcolepsy with cataplexy Other (specify): _____
 G47.419 Narcolepsy without cataplexy

G WAKIX (pitolisant) PRESCRIPTION INFORMATION Check titration prescription, maintenance prescription, or BOTH.

WAKIX Titration Prescription Take once daily in the morning, as soon as you wake up.

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) #14 8.9 mg (two 4.45-mg tablets) #14 Strength: _____
 PO once daily x 7 days Sig: _____
 17.8 mg (one 17.8-mg tablet) #23 17.8 mg (one 17.8-mg tablet) #7 Quantity: _____
 PO once daily x 23 days 35.6 mg (two 17.8-mg tablets) #32

WAKIX Maintenance Prescription Take once daily in the morning, as soon as you wake up.

WAKIX 17.8 mg WAKIX 35.6 mg Other:

17.8 mg (one 17.8-mg tablet) #30 35.6 mg (two 17.8-mg tablets) #60 Strength: _____
 PO once daily x 30 days PO once daily x 30 days Sig: _____
 Refills: _____ Refills: _____ Refills: _____

H 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 (MM/DD/YYYY) _____ Prescriber Signature _____ Date (MM/DD/YYYY) _____
 Substitution NOT permitted. Dispense as written. Substitution permitted.
 Original signature required. Signature stamp not acceptable. Original signature required. Signature stamp not acceptable.

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*In order for a WAKIX prescription to be processed, the WAKIX Prescription Referral Form must include:

- Patient name, DOB, phone number, and insurance information
- Prescriber name and NPI #
- Patient diagnosis
- Complete WAKIX prescription information
- Prescriber signature and signature date

WAKIX Prescription Referral Form (Patient Consent Information)

Fax completed form to 1-855-635-8520.



WAKIX Prescription Referral Form

Patient Consent Information
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 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 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 visiting www.harmonybiosciences.com/privacy-policy-terms-of-use.

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

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Patient Services Authorization

This section provides details regarding the patient services authorized by patient signature (refer to page 1).

These services include:

- Benefit investigation
- Copay support (when applicable)
- Additional financial support programs

Note: Enrolling in WAKIX for You is not required for a patient to receive his or her medication but a signature and date are required to determine eligibility for patient support services.

D

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Marketing Authorization

This section provides details regarding contact to receive additional marketing materials for WAKIX authorized by patient signature (refer to page 1).

Note: Enrolling in WAKIX for You is not required for a patient to receive his or her medication but a signature and date are required to receive additional marketing materials.

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



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