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.

Wakix pitolisant tablets

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 ph.:	☐ OK to leave message	

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 patient'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 #:	Group #:	Rx BIN #:	Rx PCN #:

PATIENT CONSENT INFORMATION Handwritten signature required.

Patient Services Authorization	I have read and agree to the 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**	I have read and agree to the 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/DD/YYYY)**

» **Patient or Parent/Legal Guardian** **Date (MM/DD/YYYY)**

PRESCRIBER INFORMATION

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

DIAGNOSIS CODE (ICD-10)

☐ G47.411 Narcolepsy with cataplexy
☐ G47.419 Narcolepsy without cataplexy
☐ Other (write complete ICD-10 code with diagnosis): _____

PATIENT WEIGHT

(For patients <18 years of age ONLY)
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	8.9 mg (two 4.45-mg tablets) PO once daily x 7 days	#14	Strength: _____
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	#7	Sig: _____
		35.6 mg (two 17.8-mg tablets) PO once daily x 16 days	#32	Quantity: _____

PEDIATRIC PATIENTS (6 years and older): WAKIX Titration Prescription — Take once daily in the morning, upon wakening.

The maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg once daily.

☐ **Titration to 17.8 mg** (No refills)		☐ **Titration to 35.6 mg** (No refills)		☐ **Other:** (No refills)
4.45 mg (one 4.45-mg tablet) PO once daily x 7 days	#7	4.45 mg (one 4.45-mg tablet) PO once daily x 7 days	#7	Strength: _____
8.9 mg (two 4.45-mg tablets) PO once daily x 7 days	#14	8.9 mg (two 4.45-mg tablets) PO once daily x 7 days	#14	Sig: _____
17.8 mg (one 17.8-mg tablet) PO once daily x 16 days	#16	17.8 mg (one 17.8-mg tablet) PO once daily x 7 days	#7	Quantity: _____
		35.6 mg (two 17.8-mg tablets) PO once daily x 9 days	#18	

ADULT AND PEDIATRIC (6 years and older) PATIENTS: WAKIX Maintenance Prescription — Take once daily in the morning, upon wakening.

The maximum recommended dosage for pediatric patients weighing <40 kg is 17.8 mg once daily.

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

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.

Form Number:727156

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. Original signature required. Signature stamp not acceptable.	Substitution permitted. Original signature required. Signature stamp not acceptable.

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

WAKIX Prescription Referral Form

For assistance, **call 1-855-WAKIX4U (1-855-925-4948)**, 8 AM – 8 PM ET, M-F.
Parent/Legal Guardian consent required to grant authorization on behalf of patients <18 years of age. Signature required on Page 1.

Wakix pitolisant tablets

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**

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