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.

Wakix® pitolisant tablets

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**

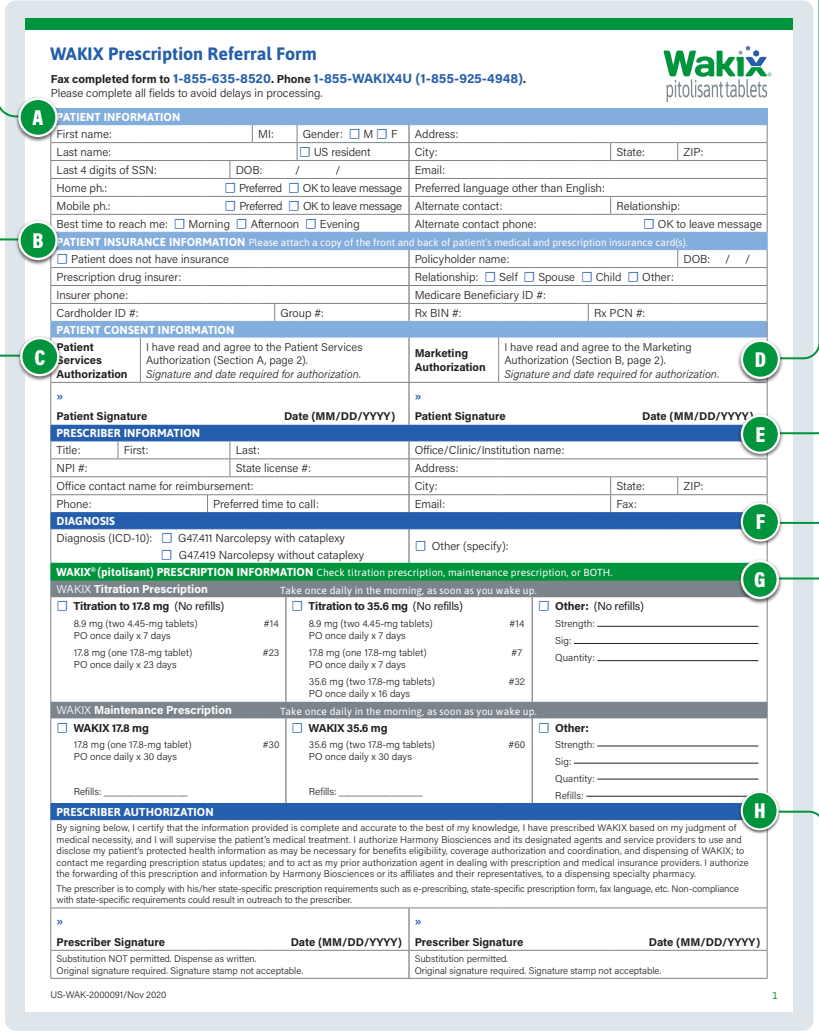
WAKIX Titration Prescription, WAKIX Maintenance Prescription, or BOTH must be selected to fill the WAKIX prescription.

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

Wakix® pitolisant tablets

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 #:

PATIENT CONSENT INFORMATION

C 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 **D**	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)

PRESCRIBER INFORMATION **E**

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:

DIAGNOSIS **F**

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

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

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

☐ **Titration to 17.8 mg** (No refills) 8.9 mg (two 4.45-mg tablets) PO once daily x 7 days #14 17.8 mg (one 17.8-mg tablet) PO once daily x 23 days #23	☐ **Titration to 35.6 mg** (No refills) 8.9 mg (two 4.45-mg tablets) PO once daily x 7 days #14 17.8 mg (one 17.8-mg tablet) PO once daily x 7 days #7 35.6 mg (two 17.8-mg tablets) PO once daily x 16 days #32	☐ **Other:** (No refills) Strength: ____ Sig: ____ Quantity: ____

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

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

PRESCRIBER AUTHORIZATION **H**

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

WAKIX Prescription Referral Form

Wakix pitolisant tablets

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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C

D

C 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 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**