Wakix (pitolisant) Prior Authorization with Quantity Limit Program Summary

This program applies to Medicaid.

The BCBS MN Step Therapy Supplement also applies to this program for Medicaid.

POLICY REVIEW CYCLE

Effective Date
02-01-2024

Date of Origin
04-01-2020

FDA APPROVED INDICATIONS AND DOSAGE

Agent(s)	FDA Indication(s)	Notes	Ref#
Wakix® (pitolisant) Tablet	Treatment of excessive daytime sleepiness or cataplexy in adult patients with narcolepsy		1

See package insert for FDA prescribing information: https://dailymed.nlm.nih.gov/dailymed/index.cfm

CLINICAL RATIONALE

Narcolepsy	Narcolepsy is a chronic neurological disorder caused by the inability to regulate sleep-wake cycles. At various times throughout the day, patients with narcolepsy experience irresistible bouts of sleep and could fall asleep. If left undiagnosed or untreated, narcolepsy can interfere with psychological, social, and cognitive function and development and can inhibit academic, work, and social activities.(2) Symptoms may include excessive daytime sleepiness (EDS), cataplexy, sleep paralysis, and hallucinations. All patients diagnosed with narcolepsy will have excessive daytime sleepiness. However, sleepiness in narcolepsy is more like a "sleep attack", where an overwhelming sense of sleepiness comes on quickly.(2) There is limited evidence to advise on treatment of special populations such as children, pregnant women, and breastfeeding mothers.(5) The American Family Physician recommends referral to a sleep clinic if narcolepsy is suspected.(3) The American Academy of Sleep Medicine (AASM) indicates treatment goals should be to alleviate daytime sleepiness and produce the fullest possible return of normal function for patients at work, school, home, and socially.(4) Excessive daytime sleepiness (EDS) is characterized by persistent sleepiness regardless of how much sleep an individual gets at night. In between sleep attacks, individuals have normal levels of alertness, particularly if doing activities that keep their attention. The most common causes of EDS include narcolepsy, obstructive sleep apnea, shift work disorder, sleep deprivation, medication effects, and other medical and psychiatric conditions.(5) Narcolepsy has two types, narcolepsy with cataplexy and without cataplexy. Narcolepsy with cataplexy involves the sudden loss of voluntary muscle tone while awake. It is often triggered by sudden, strong emotions such as laughter, fear, anger, stress, or excitement. The symptoms of cataplexy may appear weeks or even years after the onset of EDS.(2) AASM 2021 guidelines combined the recommendations for narcolepsy with cataplexy and EDS associated with narcolepsy. The AASM recommend the following for the pharmacologic treatment with narcolepsy:(6)

	• Strong treatment recommendations:
	  ○ Modafinil
	  ○ Pitolisant
	  ○ Sodium oxybate
	  ○ Solriamfetol
	• Conditional treatment recommendations:
	  ○ Armodafinil
	  ○ Dextroamphetamine
	  ○ Methylphenidate
	• There was insufficient evidence to make recommendations for SSRI and SNRIs for the treatment of narcolepsy.(6)

Efficacy	**Excessive Daytime Sleepiness (EDS) in Patients with Narcolepsy** The efficacy of Wakix for the treatment of excessive daytime sleepiness in adult patients with narcolepsy was evaluated in two multicenter, randomized, double-blind, placebo-controlled studies (Study 1; NCT01067222 and Study 2; NCT01638403). EDS was assessed using the ESS, an 8-item questionnaire by which patients rate their perceived likelihood of falling asleep during usual daily life activities.(1) Wakix demonstrated statistically significantly greater improvement on the primary endpoint, the least square mean final ESS score compared to placebo.(1) **Cataplexy in Patients with Narcolepsy** The efficacy of Wakix for the treatment of cataplexy in adult patients with narcolepsy was evaluated in two multicenter, randomized, double-blind, placebo-controlled studies (Study 3; NCT01800045 and Study 1; NCT01067222).(1) Wakix demonstrated statistically significantly greater improvement on the primary endpoint, the change in geometric mean number of cataplexy attacks per week from baseline to the average of the 4-week stable dosing period for Wakix compared to placebo.(1)
Safety	Wakix has the following contraindications for use: • Patients with severe hepatic impairment • Known hypersensitivity to pitolisant or any component of the formulation(1)

REFERENCES

Number	Reference
1	Wakix prescribing Information. Harmony Biosciences, LLC. December 2022.
2	National Institute of Neurological Disorders and Stroke. Narcolepsy Fact Sheet. NIH Publication No. 17-1637. Available at: https://www.ninds.nih.gov/health-information/disorders/narcolepsy. Accessed September 2023. Last updated October 2023.
3	Ramar, Kannan MD and Olson, Eric MD. Management of Common Sleep Disorders. Am Fam Physician. 2013 Aug 15; 88(4): 231-238.
4	Krahn, Lois MD, et al. Quality Measures for the Care of Patients with Narcolepsy. Journal of Clinical Sleep Medicine. 2015; Vol. 11(3).
5	Pagel J. Excessive daytime sleepiness. Am Fam Physician. 2009;79(5): 391-395.
6	Maski K, Trotti LM, Kotagal S, et al. Treatment of central disorders of hypersomnolence: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. 2021;17(9):1881–1893.

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Wakix	pitolisant hcl tab	17.8 MG ; 4.45 MG	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Wakix	Pitolisant HCl Tab 17.8 MG (Base Equivalent)	17.8 MG	60	Tablets	30	DAYS			
Wakix	Pitolisant HCl Tab 4.45 MG (Base Equivalent)	4.45 MG	60	Tablets	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Wakix	pitolisant hcl tab	17.8 MG ; 4.45 MG	Medicaid

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Wakix	Pitolisant HCl Tab 17.8 MG (Base Equivalent)	17.8 MG	Medicaid
Wakix	Pitolisant HCl Tab 4.45 MG (Base Equivalent)	4.45 MG	Medicaid

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Initial Evaluation **Target Agent(s)** will be approved when ALL of the following are met: 1. ONE of the following: A. The patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy AND BOTH of the following: 1. ONE of the following: A. The patient's medication history includes armodafinil OR modafinil AND ONE of the following: 1. The patient had an inadequate response to armodafinil OR modafinil **OR** 2. The prescriber has submitted an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested agent over armodafinil or modafinil **OR**

Module	Clinical Criteria for Approval
	B. The patient has an intolerance or hypersensitivity to armodafinil OR modafinil **OR** C. The patient has an FDA labeled contraindication to BOTH armodafinil AND modafinil **OR** D. The patient has been prescribed the requested non-controlled agent due to comorbid conditions OR concerns about controlled substance use **OR** E. The patient is currently being treated with the requested agent as indicated by ALL of the following: 1. A statement by the prescriber that the patient is currently taking the requested agent **AND** 2. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent **AND** 3. The prescriber states that a change in therapy is expected to be ineffective or cause harm **OR** F. The prescriber has provided documentation that armodafinil AND modafinil cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **AND** 2. ONE of the following: A. The patient's medication history includes Sunosi AND ONE of the following: 1. The patient had an inadequate response to armodafinil OR modafinil **OR** 2. The prescriber has submitted an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested agent over armodafinil or modafinil **OR** B. The patient has an intolerance or hypersensitivity to Sunosi **OR** C. The patient has an FDA labeled contraindication to Sunosi **OR** D. The patient has been prescribed the requested non-controlled agent due to comorbid conditions OR concerns about controlled substance use **OR** E. The patient is currently being treated with the requested agent as indicated by ALL of the following: 1. A statement by the prescriber that the patient is currently taking the requested agent **AND** 2. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent **AND** 3. The prescriber states that a change in therapy is expected to be ineffective or cause harm **OR** F. The prescriber has provided documentation that Sunosi cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **OR** B. The patient has a diagnosis of narcolepsy with cataplexy AND ONE of the following: 1. The patient's medication history includes armodafinil OR modafinil AND ONE of the following: A. The patient had an inadequate response to armodafinil OR modafinil **OR** B. The prescriber has submitted an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested agent over armodafinil or modafinil **OR** 2. The patient has an intolerance or hypersensitivity to armodafinil OR modafinil **OR**

Module	Clinical Criteria for Approval
	3. The patient has an FDA labeled contraindication to BOTH armodafinil AND modafinil **OR** 4. The patient has been prescribed the requested non-controlled agent due to comorbid conditions OR concerns about controlled substance use **OR** 5. The patient is currently being treated with the requested agent as indicated by ALL of the following: A. A statement by the prescriber that the patient is currently taking the requested agent **AND** B. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent **AND** C. The prescriber states that a change in therapy is expected to be ineffective or cause harm **OR** 6. The prescriber has provided documentation that armodafinil AND modafinil cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **AND** 2. If the patient has an FDA approved indication, then ONE of the following: A. The patient's age is within FDA labeling for the requested indication for the requested agent **OR** B. The prescriber has provided information in support of using the requested agent for the patient's age for the requested indication **AND** 3. The prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, psychiatrist, sleep disorder specialist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis **AND** 4. The patient does NOT have any FDA labeled contraindications to the requested agent **Length of Approval:** 12 months **Renewal Evaluation** **Target Agent(s)** will be approved when ALL of the following are met: 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process **AND** 2. The patient has had clinical benefit with the requested agent **AND** 3. The prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, psychiatrist, sleep disorder specialist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis **AND** 4. The patient does NOT have any FDA labeled contraindications to the requested agent **Length of Approval:** 12 months Note: If Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
QL with PA	**Quantity Limit for the Target Agent(s)** will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. ALL of the following: A. The requested quantity (dose) exceeds the program quantity limit **AND** B. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** C. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit **OR** 3. ALL of the following:

Module	Clinical Criteria for Approval
	A. The requested quantity (dose) exceeds the program quantity limit **AND** B. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication **AND** C. The prescriber has provided information in support of therapy with a higher dose for the requested indication **Length of Approval**: 12 months