Prior Authorization Form

Xyrem

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xyrem.

Drug Name (select from list of drugs shown)
Xyrem (sodium oxybate)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for a continuation of therapy with Xyrem (sodium oxybate)?	Y N
[If no, then skip to question 3.]	
2. Has the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy?	Y N
[If yes, then skip to question 13.]	
3. Is the requested drug being prescribed for the treatment of cataplexy in narcolepsy in a patient 7 years of age or older?	Y N

	[If yes, then skip to question 12.]	
4.	Is the requested drug being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy?	Y N
5.	Is the patient 18 years of age or older?	Y N
	[If no, then skip to question 9.]	
6.	Has the patient experienced an inadequate treatment response to armodafinil OR modafinil?	Y N
	[If yes, then skip to question 9.]	
7.	Has the patient experienced an intolerance to armodafinil OR modafinil?	Y N
	[If yes, then skip to question 9.]	
8.	Does the patient have a contraindication that would prohibit a trial of ALL of the following: A) armodafinil, B) modafinil?	Y N
9.	Has the patient experienced an inadequate treatment response to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate)?	Y N
	[If yes, then skip to question 12.]	
10.	Has the patient experienced an intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate)?	Y N
	[If yes, then skip to question 12.]	
11.	Does the patient have a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate)?	Y N
12.	Has the diagnosis been confirmed by sleep lab evaluation?	Y N
13.	Does the patient require the use of more than the plan allowance of 540 milliliters (mL) per month (270 grams per month)?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date