



Request for Prior Authorization
SODIUM OXYBATE (XYREM®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered under the following conditions: 1) A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trial and therapy failure at a therapeutic dose with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline; or 2) A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant; and 3) Patient meets the FDA approved age; and 4) Is prescribed within the FDA approved dosing; and 5) Patient and provider are enrolled in the Xyrem REMS Program; and 6) Patient has been instructed to not drink alcohol when using Xyrem®; and 7) Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and 8) Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered; and 9) The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website prior to requesting prior authorization.

Non-Preferred

Xyrem® Strength Dosage Instructions Quantity Days Supply

Cataplexy associated with Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)

Trial of preferred tricyclic antidepressant drug: Drug Name & Dose: Trial Dates: Failure Reason:

Excessive Daytime Sleepiness associated with Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)

Trial of preferred amphetamine stimulant: Drug Name & Dose: Trial Dates: Failure Reason:

Trial of preferred non-amphetamine stimulant: Drug Name & Dose: Trial dates: Failure Reason:

Medical or contraindication reason to override trial requirements:

Prescriber is enrolled in the Xyrem® REMS Program: Yes No

Patient is enrolled in the Xyrem® REMS Program: Yes No

Patient has been counseled and will be closely monitored for signs of abuse: Yes No

Patient has a semialdehyde dehydrogenase deficiency: Yes No

Patient has been instructed to not drink alcohol when using Xyrem®: Yes No

Prescriber review of patient's controlled substances use on the Iowa PMP website: Yes Date Reviewed: No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.