



Please complete ALL information below and fax your request to 1-888-671-5285

Xyrem® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for continuation of therapy	Directions for Use:	

Clinical Information (required)
Select the Type of Coverage Determination Requested: <input type="checkbox"/> Prior Authorization - Request is for a drug that requires prior authorization under the plan.
Select the diagnosis below: <input type="checkbox"/> Cataplexy in narcolepsy <input type="checkbox"/> Excessive daytime sleepiness in narcolepsy <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Prescriber's Specialty: Was the requested medication recommended by a neurologist or a sleep specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No
For excessive daytime sleepiness in narcolepsy (without cataplexy), also answer the following: Has the patient had an inadequate response to or inability to tolerate modafinil? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reauthorization: If this is a reauthorization request, answer the following questions: Is there documentation supporting the efficacy associated with the current regimen (including but not limited to reduction in the frequency of cataplexy attacks or an improvement in the Epworth sleepiness scale)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient being re-evaluated every 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.