FUTURE SCRIPTS

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

Xyrem® Prior Authorization Request Form (Page 1 of 2)

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

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Narcolepsy with cataplexy (narcolepsy type 1)

❑ Narcolepsy without cataplexy (narcolepsy type 2)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)? ❑ **Yes** ❑ **No**

Does the patient have symptoms of cataplexy? ❑ **Yes** ❑ **No**

Does the patient have symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep)? ❑ **Yes** ❑ **No**

For excessive daytime sleepiness in narcolepsy, also answer the following:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:

❑ Amphetamine-based stimulant (e.g., amphetamine, dextroamphetamine)

❑ Methylphenidate-based stimulant

Reauthorization:

If this is a reauthorization request, answer the following question:

Is there documentation demonstrating a reduction in patient's symptoms of excessive daytime sleepiness associated with Xyrem therapy? ❑ **Yes** ❑ **No**

For narcolepsy with cataplexy (narcolepsy type 1), also answer the following:

Is there documentation demonstrating a reduction in the frequency of patient's cataplexy attacks associated with Xyrem therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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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.

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