Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Xyrem (sodium oxybate) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Xyrem (sodium oxybate).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a pulmonologist (sleep specialist) or neurologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

   □ Initial therapy □ Continuing therapy, State date: _____

1. Member has enrolled in Xyrem Patient Success Program? **AND**
   □ No □ Yes

Treatment of excessive daytime sleepiness in narcolepsy:

2. Member has diagnosis of excessive daytime sleepiness in narcolepsy **AND**
   □ No □ Yes

3. Member has had an adequate trial (≥2 months) of a preferred stimulant (methylphenidate, amphetamine salt combination, dextroamphetamine) AND modafinil/armodafinil, unless contraindicated **AND**
   □ No □ Yes

4. Member has had Adequate trial of Sunosi (≥2 months) AND Wakix (≥2 months), unless contraindicated **AND**
   □ No □ Yes

5. Member is 7 years to 65 years of age **AND**
   □ No □ Yes

6. Member is not on any sedative-hypnotic agents, opioids, benzodiazepines, or alcohol **AND**
   □ No □ Yes

7. Member has had adequate trial (≥2 months) of Xywav?
   □ No □ Yes

Treatment of cataplexy due to narcolepsy:

8. Member has diagnosis of cataplexy due to narcolepsy **AND**
   □ No □ Yes
9. Member has had an adequate trial (≥2 months) of at least 2 of the following: TCAs, SSRI, or SNRI or there is a contraindication **AND**
   □ No □ Yes

10. Patient has had adequate trial (≥2 months) of Xywav?
    □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Does the member have documentation of positive clinical response to therapy? **AND**
   □ No □ Yes

2. Has the member continued to be under the care of a specialist? **AND**
   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility