



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](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel: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:

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