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 all sections, incomplete forms will delay processing. 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 all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

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

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

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: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the prescriber a Pulmonologist (Sleep Specialist) or Neurologist?
   □ No □ Yes

2. Is the prescriber enrolled in the Xyrem Patient Success Program?
   □ No □ Yes

3. Is the patient between 7 years to 65 years of age?
   □ No □ Yes

4. Is the patient on any sedative-hypnotic agents, opioids, benzodiazepines, or alcohol?
   □ No □ Yes

Treatment of excessive daytime sleepiness in narcolepsy:

5. Has the patient had an adequate trial (≥2 months) of a preferred stimulant (methylphenidate, amphetamine salt combination, dextroamphetamine) AND modafinil/armodafinil, unless contraindicated?
   □ No □ Yes

6. Has the patient had an adequate trial of Sunosi (≥2 months) AND Wakix (≥2 months), unless contraindicated?
   □ No □ Yes

7. Has the patient had an adequate trial (≥2 months) of Xywav?
   □ No □ Yes

Treatment of cataplexy due to narcolepsy:

8. Has the patient had an adequate trial (≥2 months) of at least 2 of the following: TCAs, SSRI, or SNRI or there is a contraindication?
   □ No □ Yes

9. Has the patient had an adequate trial (≥2 months) of Wakix AND Xywav, unless contraindicated?
   □ No □ Yes

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

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

2. Does the patient continue to be under the care of a specialist?
   □ 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:**