Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Xyrem

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xyrem.

Drug Name (select from list of drugs shown)
Xyrem (sodium oxybate)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for the continuation of Xyrem (sodium oxybate)?	Y N
[If no, then skip to question 3.]	
2. Has the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy?	Y N
[If yes, then skip to question 8.]	
3. Is the requested drug being prescribed for the treatment of cataplexy in narcolepsy?	Y N
[If yes, then skip to question 7.]	

4.	Is the requested drug being prescribed for the treatment excessive daytime sleepiness in a patient with narcolepsy?	Y N
5.	Did the patient experience an inadequate treatment response or intolerance to at least one CNS stimulant drug (e.g., amphetamine, dextroamphetamine, or methylphenidate) AND one CNS promoting wakefulness drug (e.g., modafinil, armodafinil)?	Y N
	[If yes, then skip to question 7.]	
6.	Does the patient have a contraindication to a CNS stimulant drug (e.g., amphetamine, dextroamphetamine, or methylphenidate) AND a CNS wakefulness promoting drug (e.g., modafinil, armodafinil)?	Y N
7.	Has the diagnosis been confirmed by sleep lab evaluation?	Y N
8.	Does the patient require the use of more than 540 mL per month?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date