CAREFIRST
Xyrem

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

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Address:

City, State, Zip: ☐☐ ☐☐☐☐☐

Drug Name (select from list of drugs shown)

Xyrem (sodium oxybate)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

1.	Is this request for a continuation of therapy with Xyrem (sodium oxybate)?	**Y** ☐	**N** ☐
2.	Has the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy?	**Y** ☐	**N** ☐
3.	Is the requested drug being prescribed for the treatment of cataplexy in narcolepsy in a patient 7 years of age or older?	**Y** ☐	**N** ☐
4.	Is the requested drug being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy?	**Y** ☐	**N** ☐
5.	Is the patient 18 years of age or older?	**Y** ☐	**N** ☐
6.	Has the patient experienced an inadequate treatment response to armodafinil OR modafinil?	**Y** ☐	**N** ☐
7.	Has the patient experienced an intolerance to armodafinil OR modafinil?	**Y** ☐	**N** ☐
8.	Does the patient have a contraindication that would prohibit a trial of ALL of the following: A) armodafinil, B) modafinil?	**Y** ☐	**N** ☐
9.	Has the patient experienced an inadequate treatment response to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate)?	**Y** ☐	**N** ☐

10.	Has the patient experienced an intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate)?	**Y** ☐	**N** ☐
11.	Does the patient have a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate)?	**Y** ☐	**N** ☐
12.	Has the diagnosis been confirmed by sleep lab evaluation?	**Y** ☐	**N** ☐
13.	Does the patient require the use of more than the plan allowance of 540 milliliters (mL) per month (270 grams per month)?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date