iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
OXYBATE PRODUCTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for oxybate products. Payment for non-preferred agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:

1. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **A diagnosis of cataplexy associated with narcolepsy**
   a. **Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and**
   b. **Previous trial and therapy failure with dextroamphetamine ; or**
3. **A diagnosis of excessive daytime sleepiness associated with narcolepsy**
   a. **Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and**
   b. **Previous trial and therapy failure at a therapeutic dose with modafinil; or**
4. **A diagnosis of idiopathic hypersomnia**
   a. **Confirmed by a sleep study (including PSG, MSLT, and ESS) and verified by a sleep specialist (attach results); and**
   b. **Previous trial and therapy failure at a therapeutic dose with modafinil; and**
5. **Will not be used in combination with other oxybate products or with pitolisant and/or solriamfetol; and**
6. **Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and**
7. **The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website prior to requesting prior authorization.**

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

☐ Sodium Oxybate ☐ Xyrem ☐ Xywav

Strength **Dosage Instructions** **Quantity** **Days Supply**

_____ _____ _____ _____

☐ **Cataplexy associated with Narcolepsy (Please provide results from ESS, MSLT, and PSG verified by a sleep specialist)**

Trial of dextroamphetamine:

Drug Name & Dose: _____

Trial Dates: _____ Failure Reason: _____

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☐ **Excessive Daytime Sleepiness associated with Narcolepsy (Please provide results from ESS, MSLT, and PSG verified by a sleep specialist)**

Trial of modafinil: Dose: _____

Trial Dates: _____

Failure Reason: _____

☐ **Idiopathic Hypersomnia (Please provide results from ESS, MSLT, and PSG verified by a sleep specialist)**

Trial of modafinil: Dose: _____ **Trial Dates:** _____

Failure Reason: _____

_____

Will medication be used in combination with other oxybate products or with pitolisant and/or solriamfetol?

☐ Yes ☐ No

Patient has been counseled and will be closely monitored for signs of abuse: ☐ Yes ☐ No

Prescriber review of patient's controlled substances use on the Iowa PMP website:

☐ Yes Date Reviewed:_____ ☐ No

Medical or contraindication reason to override trial requirements: _____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*