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
SODIUM 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 is required for sodium oxybate containing products. Payment will be considered under the following conditions: 1) A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trial and therapy failure at a therapeutic dose with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline; or 2) A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant; and 3) Patient meets the FDA approved age; and 4) Is prescribed within the FDA approved dosing; and 5) Patient and provider are enrolled in the Xyrem REMS Program; and 6) Patient has been instructed to not drink alcohol when using Xyrem®; and 7) Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and 8) Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered; and 9) The presciber 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 use of these agents would be medically contraindicated.

Non-Preferred

☐ Xyrem ☐ Xywav

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

☐ **Cataplexy associated with Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)**

Trial of preferred tricyclic antidepressant drug: Drug Name & Dose: _____
Trial Dates: _____ Failure Reason: _____

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

Trial of preferred amphetamine stimulant: Drug Name & Dose: _____ Trial Dates: _____
Failure Reason: _____
Trial of preferred non-amphetamine stimulant: Drug Name & Dose: _____Trial dates: _____
Failure Reason: _____

Medical or contraindication reason to override trial requirements: _____

Prescriber is enrolled in the Xyrem® REMS Program: ☐ Yes ☐ No

Patient is enrolled in the Xyrem® REMS Program: ☐ Yes ☐ No

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

Patient has a semialdehyde dehydrogenase deficiency: ☐ Yes ☐ No

Patient has been instructed to not drink alcohol when using Xyrem®: ☐ Yes ☐ No

Prescriber review of patient's controlled substances use on the Iowa PMP website: ☐ Yes Date Reviewed:_____ ☐ No

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 Human Services, that the member continues to be eligible for Medicaid.*