AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Xyrem

Beneficiary Information

1. Beneficiary Last Name: ______________________________ 2. First Name: ______________________________
3. Beneficiary ID #: __________________ 4. Beneficiary Date of Birth: __________ 5. Beneficiary Gender: ________

Prescriber Information

6. Prescriber Name: ____________________________________ NPI #: _______________________
Mailing address: ____________________________________ City: ____________ State: ________ ZIP: ______
7. Requester Contact Information: ____
Name: _____________________________ Phone #: _____________________ Fax #: ______________________

Drug Information

8. Drug Name: _________________________ 9. Strength: ______________ 10. Quantity Per 30 Days: _________
11. Length of Therapy : Initial Authorization: ___up to 30 days ___60 days ___90 days
Reauthorization: ___up to 30 days ___60 days ___90 days ___120 days ___180 days

Clinical Information

1. Is the beneficiary 7 years of age or older? Yes___ No___
2. Does the beneficiary have any current use of alcohol or sedative hypnotics? Yes___ No___
3. Does the beneficiary have succinic semialdehyde dehydrogenase deficiency? Yes___ No___
4. Has the beneficiary been evaluated for history of drug abuse? Yes___ No___
5. Will the prescriber monitor the beneficiary for signs of misuse or abuse of sodium oxybate (a.k.a. gamma-hydroxybutyrate [GHB]) including, but not limited to, the following: Use of increasingly large doses, increased frequency of use, drug-seeking behavior, feigned cataplexy, etc.? Yes___ No___
6. Does the beneficiary have a diagnosis of cataplexy associated with narcolepsy? Yes___ No___
7. Does the beneficiary have a diagnosis of excessive daytime sleepiness due to narcolepsy with daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for $\geq$ 3 months? Yes___ No___
8. Does the beneficiary have hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine, or substance use has been ruled out? Yes___ No___

For continuation of therapy, please answer questions 1-10

9. For a diagnosis of Excessive Daytime Sleepiness, has the beneficiary responded to therapy with a reduction in excessive daytime sleepiness from pre-treatment baseline measured by a validated scale (e.g., Epworth Sleepiness Scale, Stanford Sleepiness Scale, Karolinska Sleepiness Scale, Cleveland Adolescent Sleepiness Questionnaire, or a Visual Analog Scale)?
Yes___ No___
10. For a diagnosis of cataplexy, has the beneficiary had a reduced frequency of cataplexy attacks from pre-treatment baseline?
Yes___ No___

Signature of Prescriber: __________________________ Date: ____________________

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406