AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Xywav

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 ___120 days ___180 days ___365 days
Reauthorization: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days

Clinical Information

For diagnoses of Cataplexy or Excessive Daytime Sleepiness (EDS) associated with Narcolepsy (questions 1-8)

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 a 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 ≥ 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 Diagnosis of Idiopathic Hypersomnia (questions 9- 17)

9. Does the beneficiary have a diagnosis of idiopathic hypersomnia with daytime lapses into sleep or an irrepressible need to sleep on a daily basis for > 3 months? Yes___ No___
10. Is insufficient sleep syndrome confirmed as absent? Yes___ No___
11. Does Multiple Sleep Latency Test (MSLT) show fewer than 2 sleep-onset REM periods (SOREMPs, which are REM sleep periods within 15 minutes of sleep onset) or no SOREMPs, if the REM latency on the preceding overnight sleep study was less than or equal to 15 minutes? Yes___ No___
12. Is the average sleep latency less than or equal to 8 minutes on MSLT? Yes___ No___
13. Is the total 24- hour sleep time greater than or equal to 660 minutes? Yes___ No___
14. Does the beneficiary have cataplexy? Yes___ No___
15. Has hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use been ruled out? Yes___ No___
16. Is the beneficiary ≥ 18 years of age? Yes___ No___
17. Has the beneficiary tried and failed on a preferred formulation of modafinil or does the beneficiary have a contraindication or intolerance to an adequate trial with a preferred formulation of modafinil? Yes___ No___

For continuation of therapy, please answer questions above and below relative to the beneficiary's diagnosis.

18. For a diagnosis of Excessive Daytime Sleepiness or Idiopathic Hypersomnia, 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___
19. 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