



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/chp-forproviders/pharmacy

Xyrem Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information					
Member Name (first & last):	Date of Birth:	Gender:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Member ID:	City:	State:		Weight:	
Prescribing Provider Information					
Provider Name (first & last):	Specialty:	NPI#		DEA#	
Office Address:	City:	State:		Zip Code:	
Office Contact:		Office Phone		Office Fax:	
Dispensing Pharmacy Information					
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information					
What medication(s) has the member tried and failed for this diagnosis? Please specify:					
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one):		Diagnosis:		ICD-10 Code:	
No		Yes			
Are there any contraindications to formulary medications? If yes, please specify:			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request
Directions for Use:			Strength:		Dosage Form:
			Quantity:	Day Supply:	Duration of Therapy/Use:
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____			
Clinical Information					
<input type="checkbox"/> Severe Narcolepsy with cataplexy					
<input type="checkbox"/> Severe Narcolepsy with excessive daytime sleepiness					
Are BOTH, prescriber and member, enrolled in the Xyrem Risk Evaluation and Mitigation Strategy (REMS) Program?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have succinic semialdehyde dehydrogenase deficiency?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member currently on ANY Central Nervous System (CNS) depressants?	
Was a polysomnography completed?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Polysomnography results indicate the following:		<input type="checkbox"/> At least 6 hours of sleep time occurred during overnight polysomnogram		<input type="checkbox"/> Other conditions of sleepiness have been ruled out	
Was a Multiple sleep latency test (MSLT) completed?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
MSLT was completed AND results indicate the following:		<input type="checkbox"/> Mean sleep latency is ≤8 min		<input type="checkbox"/> There are ≥2 Sleep Onset Rapid Eye Movement (SOREM) periods (within 15 min of sleep onset)	
				<input type="checkbox"/> SOREM period was identified on polysomnography AND MSLT shows ONE SOREM period	
<input type="checkbox"/> Cataplexy					

Did member have trial and failure, or intolerance with Modafinil for a period of 60-days (PA required)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have contraindication to Modafinil?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Excessive Daytime Sleepiness					
Did member have trial and failure, or intolerance, to 2 CNS stimulants such as amphetamine, dextroamphetamine, or methylphenidate for 60 days at maximum tolerated dose ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have a contraindication to the CNS stimulants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did member have trial and failure, intolerance, or contraindication to Modafinil for 60-days (PA required)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A		
<input type="checkbox"/> RENEWAL Request ONLY					
Does member have concomitant fills for CNS depressants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is adherence to Xyrem demonstrated by prescription claims history?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Response to therapy indicates a decrease in symptoms as demonstrated by:	<input type="checkbox"/> Reduction in frequency of cataplexy attacks				
	<input type="checkbox"/> Epworth Sleepiness Scale (ESS)				
	<input type="checkbox"/> Maintenance of Wakefulness Test (MWT)?				
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Signature affirms that information given on this form is true and accurate and reflects office notes.	
Prescribing Provider's Signature: _____	Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 833-711-0776 to check the status of a request.