OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Drug Requested: **Xyrem®** (sodium oxybate)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

- To guard against diversion and misuse, the drug's distribution is limited and prescribers must adhere to a risk management protocol, the Xyrem® REMS Program.

CLINICAL CRITERIA: Check below **ALL** that apply. Boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed. Chart notes and lab results **MUST** be attached to this request.

- ❑ Patient is at least 16 years old
- ❑ Patient is **NOT** receiving treatment with sedative hypnotics, other CNS depressants **(verified by paid pharmacy claims)**
- ❑ Patient is **NOT** using alcohol
- ❑ Patient does **NOT** have a history of drug abuse

AND

- ❑ Patient has a diagnosis of narcolepsy with cataplexy **(MSLT confirming diagnosis of narcolepsy and chart notes documenting cataplexy symptoms must be submitted)**

OR

- ❑ Patient has a diagnosis of **excessive daytime sleepiness associated with narcolepsy** **AND** has failed a 30-day trial of modafanil or armodafinil **(Polysomnography and MSLT confirming diagnosis of narcolepsy must be submitted)**

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/27/2017;~~ **9/1/2018**