OPTIMA HEALTH PLAN

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. Authorization process will be delayed if incomplete.***

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 or authorization process will 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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 10/18/2012
REVISED/UPDATED: ~~3/12/2014; 11/6/2014; 5/22/2015; 12/22/2015; 5/6/2016; 5/12/2016; 6/23/2016; 12/20/2016;~~ **9/24/2017**