

Updated: 10/2023 DMMA Approved: 10/2023

Request for Prior Authorization for Xywav (calcium, magnesium, potassium and sodium oxybates) and Xyrem (sodium oxybate)

Website Form – <u>www.highmarkhealthoptions.com</u> Submit request via: Fax - 1-855-476-4158

All requests for Xywav (calcium, magnesium, potassium, and sodium oxybates) and Xyrem (sodium oxybate) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

For all requests for Xywav (calcium, magnesium, potassium, and sodium oxybates) and Xyrem (sodium oxybate) all of the following criteria must be met:

- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be prescribed by or in consultation with a neurologist or sleep specialist
- Documentation within any time frame that the member has had daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months.

Coverage may be provided with a <u>diagnosis</u> of excessive daytime sleepiness associated with narcolepsy the following criteria is met:

- Documentation of a baseline Epworth Sleepiness Scale score or Epworth Sleepiness Scale (Child and Adolescent) Score
- Documentation of at least one of the following:
 - Cerebrospinal fluid hypocretin-1 deficiency one-third less than normal or <110 pg/mL
 - o Polysomnography sleep study test with REM sleep latency \leq 15 minutes.
 - o Multiple sleep latency testing with a mean sleep latency ≤ 8 minutes and ≥ 2 sleep onset REM sleep periods (SOREMP)
- Must provide documentation showing the member has tried and failed or had an
 intolerance or contraindication to one of the following: (please note all require a prior
 authorization)
 - Modafinil
 - o Armodafinil
- If requesting Xywav, must provide documentation showing the member has tried and failed or had an intolerance or contraindication to Xyrem (sodium oxybate).

Coverage may be provided with a <u>diagnosis</u> of cataplexy with narcolepsy the following criteria is met:



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- Documentation of weekly cataplexy attacks at baseline prior to treatment with Xywav OR Xyrem
- Documentation of at least one of the following:
 - Cerebrospinal fluid hypocretin-1 deficiency one-third less than normal or <110 pg/mL
 - o Polysomnography sleep study test with REM sleep latency \leq 15 minutes.
 - O Multiple sleep latency testing with a mean sleep latency ≤ 8 minutes and ≥ 2 sleep onset REM sleep periods
- If requesting Xywav, must provide documentation showing the member has tried and failed or had an intolerance or contraindication to Xyrem (sodium oxybate).

Coverage may be provided with a <u>diagnosis</u> of idiopathic hypersomnia if the following criteria is met:

- Documentation of a baseline Epworth Sleepiness Scale score OR documentation of a baseline Idiopathic Hypersomnia Severity Score
- Insufficient sleep syndrome is confirmed absent via at least a week of wrist actigraphy or lack of improvement after an adequate trial of increased nocturnal time in bed
- Documentation of a MSLT showing fewer than 2 SOREMPs, OR, no SOREMPs, if the REM latency on the preceding sleep study was ≥ 15 minutes
- Cataplexy is confirmed to be absent
- Must provide documentation of at least one of the following:
 - o MSLT shows a mean sleep latency of ≤8 minutes
 - o Total 24-hour sleep time is ≥660 minutes (typically 12 to 14 hours) on 24-hour polysomnography or by wrist actigraphy in association with a sleep log
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to one of the following: (please note all require a prior authorization for members 21 years of age and older)
 - Modafinil
 - o Armodafinil

Initial Duration of Approval: 3 months

Reauthorization criteria

- o For Excessive daytime sleepiness associated with narcolepsy
 - Documentation of an improvement in Epworth Sleepiness Scale score from baseline
- o For cataplexy with narcolepsy
 - Documentation of a decrease in the number of cataplexy attacks from baseline
- o For idiopathic hypersomnia
 - Documentation of an improvement in Epworth Sleepiness Scale score from baseline OR improvement in Idiopathic Hypersomnia Severity Score.



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Reauthorization Duration of Approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.



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XYWAV (CALCIUM, MAGNESIUM, POTASSIUM, AND SODIUM OXYBATES) AND XYREM (SODIUM OXYBATE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation

as applicable	to Highmark Health Option						
	led, you may call to speak to						
	NE: (844) 325-6251 Monda						
	PROVIDER I			in to 7.00pm			
Requesting Provider:			NPI:				
Provider Specialty:				Office Contact:			
Office Address:				Office Phone:			
Office Address.	├	Office Fax:					
	MEMBED II	NFORMATION		١.			
Mambar Nama	MIEMIDIER II	DOB:	ON				
Member ID:					Height:		
3.6.22	REQUESTED DR						
Medication:			Strength:				
Directions:			uantity: Refills:				
Is the member currently receiving rec	☐ No						
Is this medication being used for a ch	ronic or long-term condition	n for which the	e medicat	ion may be n	ecessary for the life of the		
patient? Yes No							
Billing Information							
This medication will be billed: at a pharmacy OR medically, JCODE:							
Place of Service: Hospital Provider's office Member's home Other							
	Place of Serv	vice Informati	ion				
Name:			NPI:				
Address:			Phone:				
Diagnosis: Excessive daytime sleepiness with narcolepsy Cataplexy associated with narcolepsy Idiopathic hypersomnia							
Other:							
(Please provide chart documentation to support the above diagnosis please include sleep study results)							
If member has excessive daytime slee							
Epworth Sleepiness Scale Child and Adolescent Score: Date taken:							
If the member has cataplexy, please provide baseline number of weekly cataplexy attacks Date:							
If the member has idiopathic hypersomnia, please provide a baseline Epworth Sleepiness Scale score OR Idiopathic Hypersomnia							
Severity Score. ESS: Date:							
	CURRENT or PR			1			
Medication Name	Strength/ Frequency	Dates of T	herapy	Status (D	iscontinued & Why/Current)		
				1			
		1		1			



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XYWAV (CALCIUM, MAGNESIUM, POTASSIUM, AND SODIUM OXYBATES) AND XYREM (SODIUM OXYBATE) PRIOR AUTHORIZATION FORM (PAGE 2 of 2)

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation							
as applicable to Highmark Health Options Pharmacy Services. FAX: (855) 476-4158							
If needed, you may call to speak to a Pharmacy Services Representative.							
PHONE : (844) 325-6251 Monday through Friday 8:00am to 7:00pm							
MEMBER INFORMATION							
Member Name:	DOB:						
Member ID:	Member weight:	Height:					
REAUTHORIZATION							
Has the member experienced a significant improvement with treatment?							
If member has excessive daytime sleepiness associated with narcolepsy please provide an Epworth Sleepiness Scale score taken after							
initiating therapy: Date taken:							
If the member has cataplexy please provide the number of weekly cataplexy attacks since initiating therapy							
Date:							
If the member has idiopathic hypersomnia, please provide a Epworth Sleepiness Scale score OR Idiopathic Hypersomnia Severity							
Score since initiating therapy. ESS: Date:							
SUPPORTING INFORMATION or CLINICAL RATIONALE							
Prescribing Provider Signature	D	Pate					