

Request for Prior Authorization for Xyrem (sodium oxybate)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Xyrem (sodium oxybate) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Xyrem (sodium oxybate) Prior Authorization Criteria:

For all requests for Xyrem (sodium oxybate) all of the following criteria must be met:

- The member must be 7 years of age or older
- 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
- Provider, member, and pharmacy must be enrolled in the XYREM REMS program
- An attestation from the provider that the member is currently not taking Xyrem with any sedative hypnotic agent or alcohol
- 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 and at least one of the following:
 - Cerebrospinal fluid (CSF) hypocretin-1 deficiency one-third less than normal or <110 pg/mL
 - Polysomnogram sleep study test with REM sleep latency \leq 15 minutes
 - Multiple sleep latency testing with a mean sleep latency \leq 8 minutes with \geq 2 sleep onset REM sleep periods (SOREMP)

Coverage may be provided with a diagnosis 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
- 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)
 - Amphetamines
 - Methamphetamine
 - Dextroamphetamine
 - Methylphenidate
- 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
 - Armodafinil

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

- Documentation of weekly cataplexy attacks at baseline prior to treatment with Xyrem
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to two of the following:
 - a tricyclic antidepressant
 - a SSRI
 - venlafaxine

- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
 - For Excessive daytime sleepiness associated with narcolepsy
 - Documentation of an improvement in Epworth Sleepiness Scale score from baseline
 - For cataplexy with narcolepsy
 - Documentation of a decrease in the number of cataplexy attacks from baseline

- **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.

**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 Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> No	<input type="checkbox"/> Yes Date Medication Initiated:
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: at a pharmacy **OR**
 medically (if medically please provide a
JCODE: _____
Place of Service: Hospital Provider's office Member's home Other

Place of Service Information

Name:	NPI:
Address:	Phone:

Diagnosis: Excessive daytime sleepiness with narcolepsy Cataplexy associated with narcolepsy
Other: _____
(Please provide chart documentation to support the above diagnosis please include sleep study results)

Is the prescriber, member, and pharmacy enrolled in the XYREM REMs program? Yes No

The member is currently not taking Xyrem with any sedative hypnotic agent or alcohol Yes No

If member has excessive daytime sleepiness associated with narcolepsy please provide a baseline Epworth Sleepiness Scale score or Epworth Sleepiness Scale Child and Adolescent Score: _____
Date taken: _____

If the member has cataplexy please provide baseline number of weekly cataplexy attacks _____
Date: _____

Member Name:	DOB:
Health Options ID:	

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? Yes No

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: _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date



Updated: 1/2019
DMMA Approved: 1/2019