DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-01430 (01/15)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR XYREM®

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Xyrem® Completion Instructions, F-01430A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Xyrem® form signed by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Directions for Use

8. Refills

9. Name — Prescriber	10. National Provider Identifier — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

Note: A copy of the current medical records that support the member's condition of narcolepsy with cataplexy or narcolepsy without cataplexy needs to be submitted with the PA request, including the following:

- Results from the polysomnogram (PSG) and multiple sleep latency test (MSLT), along with provider interpretation.
- For members with excessive daytime sleepiness (EDS), a copy of the Epworth sleepiness scale (ESS) questionnaire, maintenance of wakefulness test (MWT), or MSLT.
- For renewal requests, medical records must demonstrate clinical improvement, including a decrease in cataplexy or a decrease in the member's daytime sleepiness, supported by an ESS, MWT, or MSLT.

13. Diagnosis Code and Description

14. Does the member have narcolepsy with cataplexy?	❑ Yes	❑ No
15. Does the member have narcolepsy without cataplexy?	❑ Yes	❑ No
16. Is the member 16 years of age or older?	❑ Yes	❑ No
17. Does the member have a succinic semialdehyde dehydrogenase deficiency?	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION (Continued)

18. Does the member have a documented history of abstinence from alcohol for at least the past six months? ❑ Yes ❑ No

19. Does the member have a history of substance abuse, addiction, or diversion? ❑ Yes ❑ No

20. Is the member taking any sedative hypnotics? ❑ Yes ❑ No

21. Is the member taking central nervous system (CNS) depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness? ❑ Yes ❑ No

    If yes, indicate the CNS depressants and daily doses.

    1. _____

    2. _____

    3. _____

22. Has the member had an overnight PSG sleep study followed by an MSLT? ❑ Yes ❑ No

23. Does the member have EDS that interferes with normal activities on a daily basis? ❑ Yes ❑ No

24. Has the member completed an ESS questionnaire, MWT, or MSLT? ❑ Yes ❑ No

25. Has the prescriber ruled out or treated the member for each of the following potential causes of EDS? ❑ Yes ❑ No
    - Other sleep disorders including sleep apnea.
    - Chronic pain or illness that disrupts normal sleep patterns.
    - Mood disorders such as depression.
    - Caffeine or nicotine use causing poor quality of nighttime sleep.

26. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with a stimulant? ❑ Yes ❑ No

    If yes, list the stimulant and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the stimulant was taken in the space provided.

27. Does the member have a medical condition(s) preventing the use of a stimulant? ❑ Yes ❑ No

    If yes, list the medical condition(s) that prevents the use of a stimulant in the space provided.

28. Is there a clinically significant drug interaction between another medication the member is taking and stimulants? ❑ Yes ❑ No

    If yes, list the medication(s) and interaction(s) in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

29. Has the member experienced an unsatisfactory therapeutic response after the medication has been titrated to a maximum recommended daily dose or experienced a clinically significant adverse drug reaction with modafinil or Nuvigil®? ❑ Yes ❑ No

If yes, list the drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates modafinil or Nuvigil® were taken in the space provided.

30. Does the member have a medical condition(s) preventing the use of modafinil or Nuvigil®? ❑ Yes ❑ No

If yes, list the medical condition(s) that prevents the use of modafinil or Nuvigil® in the space provided.

31. Is there a clinically significant drug interaction between another medication the member is taking and modafinil or Nuvigil®? ❑ Yes ❑ No

If yes, list the medication(s) and interaction(s) in the space provided.

32. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI), or serotonin norepinephrine reuptake inhibitor (SNRI)? ❑ Yes ❑ No

If yes, list the TCA, SSRI, or SNRI and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the TCA, SSRI, or SNRI was taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

33. **SIGNATURE** — Prescriber	34. Date Signed

SECTION V — ADDITIONAL INFORMATION

35. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

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