

**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](http://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 member's current medical records that support a clinical correlation between the member's test results and the member's condition of narcolepsy with cataplexy or narcolepsy without cataplexy needs to be submitted with the PA request, including the following:

- Test results and provider interpretation for the polysomnogram (PSG) and multiple sleep latency test (MSLT)
- 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 record documentation 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

If yes, indicate in the space below the cataplexy symptoms experienced by the member and how frequently they occur.

15. Does the member have narcolepsy without cataplexy?

Yes  No

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**SECTION III – CLINICAL INFORMATION (Continued)**

16. Is the member 16 years of age or older?  Yes  No

17. Does the member have a succinic semialdehyde dehydrogenase deficiency?  Yes  No

18. As required by the Xyrem® Risk Evaluation and Mitigation Strategy (REMS) Program:

- Has the prescriber counseled the member on the contraindication between Xyrem® and alcohol?  Yes  No
- Has the member agreed to be abstinent from alcohol while being treated with Xyrem®?  Yes  No

19. Indicate which symptom(s) of narcolepsy Xyrem is being used to treat.

- Cataplexy
- Excessive Daytime Sleepiness
- Other \_\_\_\_\_

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

21. Is the member taking any sedative hypnotics?  Yes  No

22. Is the member taking central nervous system (CNS) depressants (i.e., anxiolytics, barbiturates, opioids)?  Yes  No

If yes, indicate the CNS depressants and daily doses.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Are any of the above listed CNS depressants contributing to the member's daytime sleepiness?  Yes  No

If no, indicate how the prescriber evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.

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

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

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

26. 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

27. 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.

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**SECTION III – CLINICAL INFORMATION (Continued)**

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28. 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.

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29. 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.

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30. 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.

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31. 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.

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32. 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.

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33. 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.

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**SECTION IV – AUTHORIZED SIGNATURE**

34. **SIGNATURE** – Prescriber

35. Date Signed

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**SECTION V – ADDITIONAL INFORMATION**

36. 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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