

**FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR XYREM
AND XYWAV INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is only used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting a PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS

Prescribers are required to complete and sign the Prior Authorization Drug Attachment for Xyrem and Xywav form, F-01430. Pharmacy providers are required to use the Prior Authorization/Drug Attachment for Xyrem and Xywav form to request PA for Xyrem and Xywav by submitting a PA request on the ForwardHealth Portal, by fax, or by mail. Prescribers and pharmacy providers are required to retain a completed copy of the form.

Pharmacy providers may submit PA requests on a PA drug attachment form in one of the following ways:

- For PA requests submitted on the Portal, pharmacy providers may access www.forwardhealth.wi.gov.
- For PA requests submitted by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA drug attachment form to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, pharmacy providers should submit a PA/RF and the appropriate PA drug attachment to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

Providers and prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I – MEMBER INFORMATION

Element 1: Name – Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth ID card and the Enrollment Verification System do not match, use the spelling from the Enrollment Verification System.

Element 2: Member ID Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the Enrollment Verification System to obtain the correct member ID.

Element 3: Date of Birth – Member

Enter the member's date of birth in mm/dd/ccyy format.

SECTION II – PRESCRIPTION INFORMATION

Element 4: Drug Name

Enter the name of the drug.

Element 5: Drug Strength

Enter the strength of the drug in milligrams.

Element 6: Date Prescription Written

Enter the date that the prescription was written.

Element 7: Directions for Use

Enter the directions for use of the drug.

Element 8: Refills

Enter the number of refills.

Element 9: Name – Prescriber

Enter the name of the prescriber.

Element 10: National Provider Identifier – Prescriber

Enter the prescribing provider's National Provider Identifier for prescriptions for noncontrolled substances.

Element 11: Address – Prescriber

Enter the address (street, city, state, and zip+4 code) of the prescribing provider.

Element 12: Phone Number – Prescriber

Enter the phone number, including area code, of the prescribing provider.

SECTION III A – 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 medical condition of narcolepsy with cataplexy, narcolepsy without cataplexy, or idiopathic hypersomnia must be submitted with the PA request, including the following:

- Test results and provider interpretation for the polysomnogram 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 PA requests, medical record documentation demonstrating clinical improvement, including a decrease in cataplexy or a decrease in the member's daytime sleepiness, supported by an ESS questionnaire, MWT, or MSLT

Element 13: Diagnosis Code and Description

Enter the appropriate and most specific International Classification of Diseases diagnosis code and description most relevant to the drug requested. The International Classification of Diseases diagnosis code must correspond with the International Classification of Diseases description.

Element 14

Check the appropriate box to indicate whether or not the member has narcolepsy with cataplexy. If yes, indicate in the space provided the cataplexy symptoms experienced by the member and how frequently they occur.

Element 15

Check the appropriate box to indicate whether or not the member has narcolepsy without cataplexy.

Element 16

Check the appropriate box to indicate whether or not the member has idiopathic hypersomnia.

Element 17

Check the appropriate box to indicate whether or not the member has a succinic semialdehyde dehydrogenase deficiency.

Element 18

As required by the Xywav and Xyrem Risk Evaluation and Mitigation Strategy (REMS) Program, check the appropriate box to indicate the following:

- Whether or not the prescriber has counseled the member on the contraindication between Xyrem or Xywav and alcohol
- Whether or not the member has agreed to be abstinent from alcohol while being treated with Xyrem or Xywav

Element 19

Check the appropriate box(es) to indicate which symptom(s) of narcolepsy or idiopathic hypersomnia Xyrem or Xywav is being used to treat. If "other," enter what other symptom(s) of narcolepsy Xyrem or Xywav is being used to treat.

Element 20

Check the appropriate box to indicate whether or not the member has a history of substance abuse, addiction, or diversion.

Element 21

Check the appropriate box to indicate whether or not the member is taking any sedative hypnotics.

Element 22

Check the appropriate box to indicate whether or not the member is taking central nervous system (CNS) depressants (for example, anxiolytics, barbiturates, or opioids). If yes, indicate the CNS depressants and daily doses in the spaces provided. Also indicate whether or not any of the listed CNS depressants contribute to the member's daytime sleepiness. If not, indicate how the prescriber evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.

Element 23

Check the appropriate box to indicate whether or not the member has had an overnight polysomnogram sleep study followed by an MSLT.

Element 24

Check the appropriate box to indicate whether or not the member has EDS that interferes with normal activities on a daily basis.

Element 25

Check the appropriate box to indicate whether or not the member completed an ESS questionnaire, MWT, or MSLT.

Element 26

Check the appropriate box to indicate whether or not the prescriber has ruled out or treated the member for each of the following potential causes of EDS:

- 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

Element 27

Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant. 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.

Element 28

Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of a stimulant. If yes, list the medical condition(s) that prevents the use of a stimulant in the space provided.

Element 29

Check the appropriate box to indicate whether or not there is a clinically significant drug interaction(s) between another medication(s) the member is taking and stimulants. If yes, list the medication(s) and interaction(s) in the space provided.

Element 30

Check the appropriate box to indicate whether or not the member has 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 armodafinil or modafinil. If yes, list the drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates armodafinil or modafinil were taken in the space provided.

Element 31

Check the appropriate box to indicate whether or not the member has a medical condition(s) preventing the use of armodafinil or modafinil. If yes, list the medical condition(s) that prevents the use of armodafinil or modafinil in the space provided.

Element 32

Check the appropriate box to indicate whether or not there is a clinically significant drug interaction(s) between another medication(s) the member is taking and armodafinil or modafinil. If yes, list the medication(s) and drug interaction(s) in the space provided.

Element 33

Check the appropriate box to indicate whether or not the member has experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction with tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI), or serotonin norepinephrine reuptake inhibitor (SNRI). 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 III B – ADDITIONAL CLINICAL INFORMATION FOR XYWAV PA REQUESTS FOR NARCOLEPSY ONLY

Element 34

PA requests for Xywav must include detailed clinical justification for prescribing Xywav instead of Xyrem. This clinical information must document why the member cannot use Xyrem, including why it is medically necessary that the member receive Xywav instead of Xyrem.

SECTION IV – AUTHORIZED SIGNATURE

Element 35: Signature – Prescriber

The prescriber is required to complete and sign this form.

Element 36: Date Signed

Enter the month, day, and year the form was signed in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 37

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