pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

XYREM *(sodium oxybate)* / XYWAV *(calcium, magnesium, potassium, and sodium oxybates)*

PRIOR AUTHORIZATION FORM *(form effective 1/10/2023)*

Prior authorization guidelines for Xyrem / Xywav and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:
- ☐sodium oxybate 0.5 g/mL (500 mg/mL) oral solution
- ☐Xyrem *(sodium oxybate)* 0.5 gm/mL (500 mg/mL) oral solution
- ☐Xywav *(calcium, magnesium, potassium, and sodium oxybates)* 0.5 gm/mL (500 mg/mL) oral solution
- ☐other: _____

Directions:	Quantity (mL):	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	Weight (kg):

Does the beneficiary have hepatic impairment?	☐Yes ☐No	*Submit documentation.*
Will the beneficiary be taking divalproex sodium (e.g., Depakote, Depakote ER) while taking the requested medication?	☐Yes ☐No	*Submit complete medication list.*
Will the beneficiary be taking any sedative hypnotics while taking the requested medication?	☐Yes ☐No	*Submit complete medication list.*
Was the beneficiary counseled to avoid alcohol while taking the requested medication?	☐Yes ☐No	*Submit documentation.*
Does the beneficiary have active or untreated substance abuse or addiction or a history of diversion?	☐Yes ☐No	*Submit documentation.*
Did the prescriber or prescriber's delegate search the PDMP to review the beneficiary's controlled substance prescription history before issuing this prescription for the requested agent?	☐Yes ☐No	*Submit documentation.*
INITIAL Requests		
Does the beneficiary have results of a recent urine drug screen (UDS) that includes testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol?	☐Yes ☐No	*Submit documentation.*

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐For treatment of excessive daytime sleepiness in narcolepsy:
- ☐Was evaluated and treated for other etiologies of excessive daytime sleepiness (e.g., sleep-related breathing disorders, circadian rhythm sleep-wake disorders, sleep-related movement disorders, neurological disorders, psychiatric disorders, etc.)

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- ☐ For a beneficiary under 18 years of age:
  - ☐ Tried and failed maximum tolerated doses of armodafinil or modafinil
  - ☐ Has a contraindication or an intolerance to armodafinil or modafinil
- ☐ For a beneficiary 18 years of age or older:
  - ☐ Tried and failed maximum tolerated doses of the following:
    - ☐ armodafinil or modafinil
    - ☐ Sunosi (solriamfetol)
    - ☐ Wakix (pitolisant)
  - ☐ Has a contraindication or an intolerance to:
    - ☐ armodafinil or modafinil
    - ☐ Sunosi (solriamfetol)
    - ☐ Wakix (pitolisant)

☐ For treatment of cataplexy in narcolepsy:
- ☐ For a beneficiary under 18 years of age:
  - ☐ Tried and failed an antidepressant (i.e., SSRI, SNRI, TCA)
  - ☐ Has a contraindication or an intolerance to antidepressants (i.e., SSRI, SNRI, TCA)
- ☐ For a beneficiary 18 years of age or older:
  - ☐ Tried and failed the following:
    - ☐ Wakix (pitolisant) ☐ Antidepressants (i.e., SSRI, SNRI, TCA)
  - ☐ Has a contraindication or an intolerance to the following:
    - ☐ Wakix (pitolisant) ☐ Antidepressants (i.e., SSRI, SNRI, TCA)

☐ For treatment of idiopathic hypersomnia:
- ☐ Was diagnosed with idiopathic hypersomnia by or in consultation with a sleep specialist
- ☐ Was evaluated and treated for other etiologies of excessive daytime sleepiness (e.g., sleep-related breathing disorders, circadian rhythm sleep-wake disorders, sleep-related movement disorders, neurological disorders, psychiatric disorders, etc.)
- ☐ Tried and failed maximum tolerated doses of armodafinil or modafinil
- ☐ Has a contraindication or an intolerance to armodafinil or modafinil

☐ For Xywav *(calcium, magnesium, potassium, and sodium oxybates)*:
- ☐ Has a clinical reason why Xyrem (sodium oxybate) cannot be used

RENEWAL Requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ For treatment of excessive daytime sleepiness in narcolepsy:
- ☐ Experienced a reduction in daytime sleepiness

☐ For treatment of cataplexy in narcolepsy:
- ☐ Experienced a reduction in the incidence of cataplexy attacks

☐ For treatment of idiopathic hypersomnia:
- ☐ Experienced a reduction in daytime sleepiness

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: