| Prescriber Criteria Form<br><br>Xyrem 2024 PA Fax 1481-A v2 010124.docx<br>Xyrem (sodium oxybate)<br>Coverage Determination |
|---|
| This fax machine is located in a secure location as required by HIPAA regulations.<br>Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.<br>Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.<br>When conditions are met, we will authorize the coverage of Xyrem (sodium oxybate). |

| Drug Name:<br>Xyrem (sodium oxybate) |
|---|

| | | |
|---|---|---|
| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
|---|---|---|---|
| 1 | Is the requested drug being prescribed for the treatment of cataplexy in narcolepsy in a patient 7 years of age or older?<br>[If no, then skip to question 4.] | Yes | No |
| 2 | Is this request for a continuation of therapy with Xyrem (sodium oxybate)?<br>[If no, then skip to question 12.] | Yes | No |
| 3 | Has the patient experienced a decrease in cataplexy episodes with narcolepsy?<br>[If yes, then skip to question 13.]<br>[If no, then no further questions.] | Yes | No |
| 4 | Is the requested drug being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy?<br>[If no, then no further questions.] | Yes | No |
| 5 | Is this request for a continuation of therapy with Xyrem (sodium oxybate)?<br>[If no, then skip to question 7.] | Yes | No |
| 6 | Has the patient experienced a decrease in daytime sleepiness with narcolepsy?<br>[If yes, then skip to question 13.]<br>[If no, then no further questions.] | Yes | No |

| | | | |
|---|---|---|---|
| 7 | Is the patient 18 years of age or older?<br>[If no, then skip to question 10.] | Yes | No |
| 8 | Has the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil)?<br>[If yes, then skip to question 12.] | Yes | No |
| 9 | Does the patient have a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil)?<br>[If yes, then skip to question 12.]<br>[If no, then no further questions.] | Yes | No |
| 10 | Has the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate)?<br>[If yes, then skip to question 12.] | Yes | No |
| 11 | Does the patient have a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate)?<br>[If no, then no further questions.] | Yes | No |
| 12 | Has the diagnosis been confirmed by sleep lab evaluation?<br>[If no, then no further questions.] | Yes | No |
| 13 | Is the requested drug being prescribed by or in consultation with a sleep disorder specialist or neurologist? | Yes | No |

| | |
|---|---|
| Comments: | _____ |

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** _____ **Date:**_____