

OXYBATE

PRIOR AUTHORIZATION

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Narcolepsy with cataplexy <input type="checkbox"/> Narcolepsy with excessive daytime sleepiness <input type="checkbox"/> Idiopathic hypersomnia <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____	
3. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for using the requested agent for the patient’s age for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____	
4. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g. sleep specialist, neurologist, psychiatrist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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6. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
- If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?..... Yes No
- If no, is there documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? Please note, chart notes are required. Yes No
- If yes, please submit chart notes.
- If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?..... Yes No

For narcolepsy with cataplexy OR narcolepsy with excessive daytime sleepiness requests:

7. Has the patient tried and had an inadequate response to ONE prerequisite agent? The prerequisite agents are modafinil and armodafinil..... Yes No
- If yes, please specify agent tried: _____
8. Was ONE prerequisite agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? The prerequisite agents are modafinil and armodafinil..... Yes No
9. Does the patient have an intolerance or hypersensitivity to ONE prerequisite agent? The prerequisite agents are modafinil and armodafinil..... Yes No
- If yes, please explain intolerance/hypersensitivity: _____
10. Does the patient have an FDA labeled contraindication to ALL prerequisite agent(s)? The prerequisite agents are modafinil and armodafinil..... Yes No
- If yes, please specify FDA labeled contraindication: _____
11. Is ONE prerequisite agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? The prerequisite agents are modafinil and armodafinil. Yes No
12. Is ONE prerequisite agent not in the best interest of the patient based on medical necessity? The prerequisite agents are modafinil and armodafinil..... Yes No
13. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE prerequisite agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? The prerequisite agents are modafinil and armodafinil..... Yes No

For idiopathic hypersomnia requests:

14. Has the patient completed a sleep study? Yes No
15. Have all other causes of hypersomnia have been ruled out? Yes No
16. Has the patient tried and had an inadequate response to modafinil? Yes No
- If no, does the patient have an intolerance or hypersensitivity to modafinil?..... Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to modafinil? Yes No
- If yes, please specify FDA labeled contraindication: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For brand Xyrem requests:

17. Has the patient tried and had an inadequate response to authorized generic Sodium Oxybate? Yes No
18. Was authorized generic Sodium Oxybate discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
19. Does the patient have an intolerance or hypersensitivity to authorized generic Sodium Oxybate that is not expected to occur with the requested agent? Yes No
 If yes, please explain intolerance/hypersensitivity: _____
20. Does the patient have an FDA labeled contraindication to authorized generic Sodium Oxybate that is not expected to occur with the requested agent? Yes No
 If yes, please specify FDA labeled contraindication: _____
21. Is authorized generic Sodium Oxybate expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?..... Yes No
22. Is authorized generic Sodium Oxybate not in the best interest of the patient based on medical necessity? Yes No
23. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as authorized generic Sodium Oxybate and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
24. Is there information to support the use of the requested brand agent over authorized generic Sodium Oxybate? Yes No
 If yes, please provide supporting information: _____

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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